DOCUMENT RESUME

ED 050 263 VT 012 939

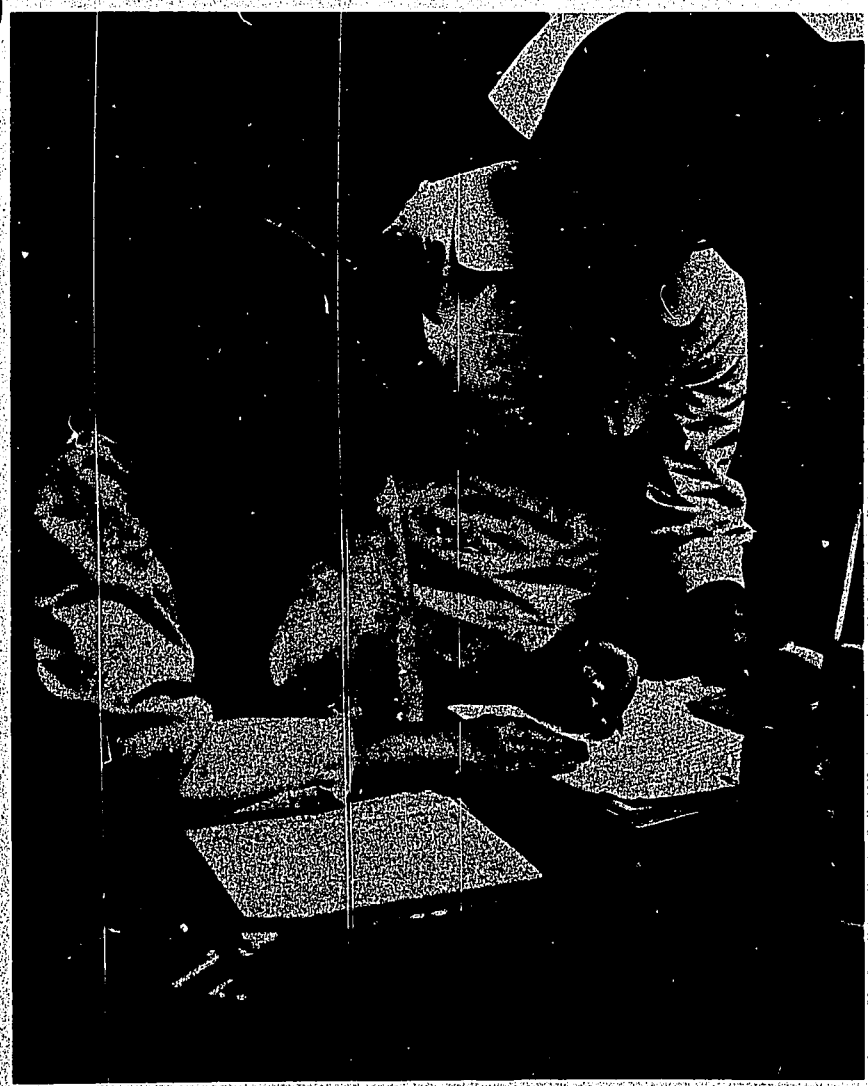
AUTHOR	Jelinek, Richard C.; And Others
TITLE	SUM (Service Unit Management): An Organizational Approach To Improved Patient Care.
SPONS AGENCY	Kellogg Foundation, Battle Creek, Mich.
PUB DATE	Feb 71
NOTE	113p.
EDRS PRICE	EDRS Price MF-$0.65 HC-$6.58
DESCRIPTORS	*Administration, Annotated Bibliographies, Cost Effectiveness, *Differentiated Staffs, *Health Services, *Hospitals, *Management Systems, Personnel Evaluation, Staff Utilization, Subprofessionals, Unit Costs
IDENTIFIERS	Nonnursing Tasks, *Service Unit Management, SUM

ABSTRACT

To evaluate the effectiveness of Service Unit Management (SUM) in reducing costs, improving quality of care, saving professional nursing time, increasing personnel satisfaction, and setting a stage for further improvements, a national questionnaire survey identified the characteristics of SUM units, and compared the performance of a total of 55 units with and without SUM. Data collected from each unit included personnel costs, quality of care, patient work load, personnel satisfaction, organizational tension and management style, personnel acceptance of SUM, assignment of responsibility, and type of SUM organization. Evaluation by a multi-disciplinary research team, representing the disciplines of industrial engineering, organizational science, and social psychology, revealed that in general SUM was serving the purposes claimed. In addition, the activities which characterize a unit management program were grouped as logistic and clerical, patient support, and administrative activities. Other findings are provided for the focus of SUM, organizational structure, unit manager qualifications, and the change process. An activities list and additional readings are appended, and an annotated bibliography of current literature on SUM is included. (SB)

SUM:

An organizational approach to improved patient care



A study report for
THE W.K. KELLOGG FOUNDATION
Battle Creek, Michigan

This brochure is one of a series of periodical publications relating to health care. Of this series, currently available upon request to the Foundation at the address shown on the opposite page are the following: *Taking the Hospital to the Patient: Home Care for the Small Community; The Improvement of Long-Term Care; An Experience in Developing an Extended Care Unit at Memphis, Tennessee; Hospital-Based Long-Term Patient Care Units in Wisconsin (Part One); The Improvement of Long-Term Care: A New Responsibility for Community Hospitals;* and *Coronary Care Units in Small Hospitals—The Standish (Michigan) Experience.*

SUM (service unit management):
An organizational approach to improved patient care

by

Richard C. Jelinek, Ph.D., formerly Associate Professor of Hospital Administration and Associate Professor of Industrial Engineering, The University of Michigan; currently Vice President for Research and Development, Medicus Corporation, 1104 Expressway Tower, Dallas, Texas 75206.

Fred Munson, Ph.D., Associate Professor of Hospital Administration, The University of Michigan, Ann Arbor.

Robert L. Smith, Ph.D., Research Associate in the Bureau of Hospital Administration, The University of Michigan, Ann Arbor.

This study was conducted and published under a grant from the W. K. Kellogg Foundation, 400 North Avenue, Battle Creek, Michigan 49016.

February 1971

CONTENTS

FIGURES

TABLES

PHOTOGRAPHIC CREDITS

Cover: Peter Bent Brigham Hospital; page 6: Borgess Hospital; page 10: (top) Presbyterian St. Luke's Hospital; (bottom) William Beaumont Hospital; page 30: (top) University of Michigan; (bottom) Borgess Hospital; page 34: William Beaumont Hospital; page 56: Massachusetts General Hospital; and page 114: Borgess Hospital.

ACKNOWLEDGEMENTS

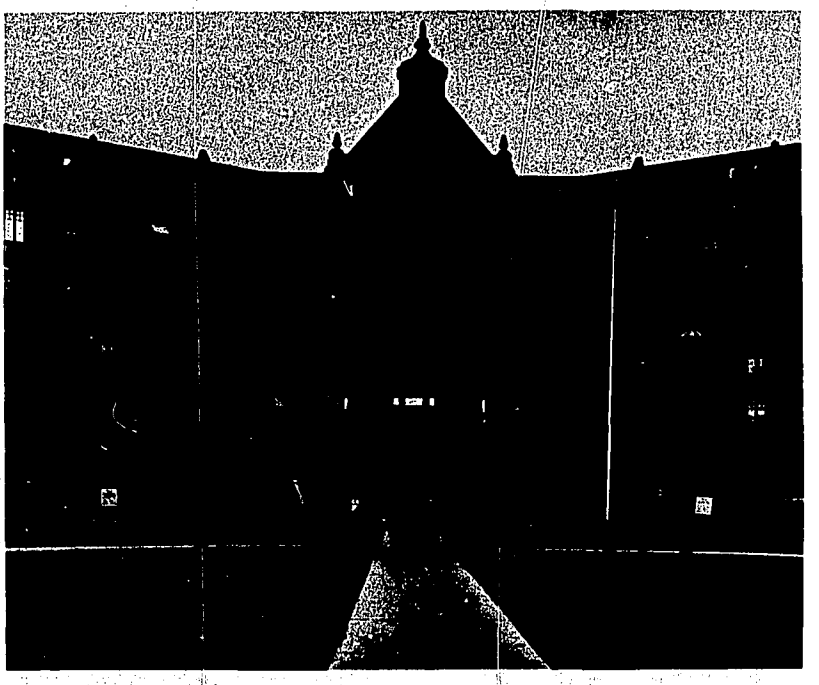
The authors wish to express their appreciation to several persons who participated in various phases of the study. Major contributions from The University of Michigan during the periods of study design, instrument development, and pretesting were Lawrence A. Hill, then Director of the Bureau of Hospital Administration; Rae Smith, Research Associate, a nurse who kept us honest about nursing; Louis Freund, an Industrial Engineer; and Jane Grabois, Research Assistant. Observations during the data collection period were ably handled by Sue Moon, R.N., who, assisted by June Teich, R.N., was responsible for the quality of patient care observations and Nancy Hangus, R.N., who trained and supervised the work sampling staff. Milla Cummins, Research Assistant, kept us all well supplied with the materials we needed in the field. Data analysis was facilitated by the help of Shyam Heda, Research Associate, who kept us supplied with output from the computer, Glenna Petersen, Research Assistant, and many others too numerous to mention.

We wish to thank John R. Griffith, current Director of the Bureau and Barbara J. Lee, Program Director, W. K. Kellogg Foundation for significant criticisms of an earlier draft and especially Lewis E. Weeks, Bureau Managing Editor, and Connie Polasky, Foundation Communications Director, whose thorough editing has made it readable. Finally, we wish to thank Andrea Sperlbaum, former Bureau Librarian, who compiled and annotated the original bibliography and who, with assistance from Anita Goor, current Bureau Librarian, brought the bibliography up-to-date.

We should like to state our sincere appreciation to the hospitals which served as field sites and the personnel of those hospitals whose cooperation made our data collection possible. These hospitals and key personnel were: William Beaumont Hospital, Royal Oak, Michigan, Owen R. Pinkerman, the Director then and Eleanor Taylor, Director, Clinical Nursing Division; Borgess Hospital, Kalamazoo, Michigan, Martin A. Verzi, Administrator, and Lillian Martin, R.N., management consultant to nursing; University Hospital, Ann Arbor, Michigan, Dr. Roger Nelson, the Senior Associate Director then, and Arlene Howe, R.N., Staff Specialist; Georgetown University Hospital, Washington, D.C., Sister Rachel Strittmatter, Assistant Administrator; Toledo Hospital, Toledo, Ohio, Wilson F. Benfer, Administrator and Mary Corrigan, R.N., Assistant Administrator; Presbyterian—St. Luke's Hospital, Chicago, Illinois,

Gail L. Warden, Vice-President for Administration and David Buchmueller, Assistant Administrator; University of Chicago Hospitals and Clinics, Charles R. Goulet, the Director then and Jane Kennedy, R.N., Assistant Director of Nursing in charge of In-service Education; Massachusetts General Hospital, Boston, Massachusetts, Ellsworth T. Neumann, M.D., Administrator and Mary McDonald, R.N., Director of Nursing; Peter Bent Brigham Hospital, Boston, Massachusetts, William E. Hassan, Jr., Ph.D., Director and Marian Metcalf, R.N., Director of Nursing; Providence Hospital, Southfield, Michigan, Earnest Johns, Administrative Assistant and Mary Morris, R.N., Assistant Director of Nursing in charge of In-service Education. These persons represent only a few of the many who aided us.

Finally, we should like to state our sincere appreciation to the W. K. Kellogg Foundation for financing the study and this publication and to Andrew Pattullo, Program Director, for his continuing support and encouragement.



Borgess Hospital, Kalamazoo, Michigan, one of the study hospitals.

FOREWORD

This report of a study of the process of bringing rational economic and organizational decisions into an environment where professionals practice may be viewed as a companion piece to the report of the *National Commission for the Study of Nursing and Nursing Education.* A growing number of nurses have become increasingly vocal in their demands for increased emphasis on clinical practice and the report of the Commission stresses the urgency that nursing must be *allowed*—and *required*—to practice at its very highest capacity. The underlying issues and problems most frequently cited by nurses, as impediments to practice, have been that the hospital system deluges the nurse with work that involves administration, supervision and training and that patient care becomes more and more remote.

The facts are quite evident for study after study has revealed that only about 25–75% of the skills of registered nurses are available for patient care services. It has been widely assumed by nurses as well as by administration and physicians that relieving the nurse of non-professional duties would enhance the quality of nursing care through the availability of more nursing time for direct patient care services. But the report of the appraisal of the Service Unit Management concept clearly isolated a recurring and persistent problem of nursing service. For although the professional staff was relieved by selected non-professional activities, their time shifted only in part to patient centered activities. The major problem, similar to the findings of the Commission, was the absence of a reorientation of the nurse practitioner as well as absence of clear cut objectives and goals for the nurse.

This report clearly depicts the interrelation of organizational change to the potential for changes in traditional practices of nurses as well as other health service personnel—changes in the work habits, attitudes and values of personnel. Certainly the need for nurses to place greater emphasis on and recognition of skilled nursing practice is not debatable. But if an organizational system facilitates divestment of non-nursing functions that are time consuming, nurses must assume responsibility for the redirection of nursing time and effort toward actual practice.

Eleanor C. Lambertsen, *Dean*
Cornell University-New York Hospital School of Nursing

8 / Service Unit Management

Great emphasis is being given today to the external affairs of hospitals and the manner in which the individual hospital fits into the community and the total health care organization. This concern is appropriate and necessary if hospitals and the health care system are to maximize their effectiveness—but it only deals with one side of the coin. The internal affairs of hospitals have much to do with hospital effectiveness and efficiency. No matter how well designed the hospital and health care system, its ultimate purpose and performance resides at the point where things are done for and to individuals. That is where the action is and the most crucial and costly segment of that action occurs on the patient care unit of the general hospital. That is also the site of the most complex and difficult management situation in American enterprise. At that point a myriad of diverse activities must be merged into a cohesive, individualized service for each patient located on the patient care unit.

In the last decade considerable concern developed regarding the organization of the patient care unit. Various organizational models were developed and tried. In general, these consisted of a structure that treated the patient care unit as a unified entity conducted as a support service for the medical and nursing services. This report represents the most comprehensive and detailed evaluation yet made of service unit management. It evaluates the concept under actual working conditions on eight significant parameters and provides definitive knowledge that hospital administration very badly needs in order to move ahead with the organizational restructuring of the most crucial and expensive service site in the health care field.

Ray E. Brown, *Executive Vice President*
Northwestern University-McGraw Medical Center

It is paradoxical that public pride generated by the great medical advances of the forties and fifties is now turning to general unhappiness and even open hostility because of the costs and ineffectiveness of the medical care delivery system. This attitude is not surprising because when we did not know much there was not much to do and it did not cost much. The medical scientific and technical revolution did not diminish the need for facilities and personnel—it stimulated an easy going profession into an unprepared, unexpected and even unwelcome third largest industry in our nation. Our problems and inadequacies are ascribed to a number of different causes, most of them true, i.e., too many

people, too much government, obsolete facilities, not enough money, etc. The remedy according to most authoritative sources is to fill the gaps of deficient medical manpower, all categories, by doubling the size and number of medical schools, pouring untold millions into new professional and technical training programs and a multitude of lesser schemes. If we are realistic, we must accept the fact that it is not possible to satisfy the medical needs of modern society by trying to refine a system poorly designed and barely adequate a half century ago.

Much effort needs to be expended on devising better means of distributing the talents of highly trained personnel. There must be more discriminating exploitation of expensive facilities in accordance with the medical needs of patients. The health industry is among the largest employers of personnel and new management techniques such as SUM are mandatory.

After two or more decades of an accelerating rate of nursing personnel shortage, the physician should seize upon and assist in the implementation of programs such as SUM as one means of providing effective assistance programs which currently are inferior or absent.

Lowell T. Coggeshall, M.D.
Vice President Emeritus and Trustee,
University of Chicago

INTRODUCTION

SUM, also referred to as Service Unit Management or Ward Management, is an organizational concept for patient care units in hospitals. Under SUM the responsibility for carrying out certain non-nursing tasks is given to a unit or ward manager whose staff works separately from the nursing organization.

Several versions of SUM are in use and vary at least two ways: (1) the place of SUM in the hospital organization; and (2) the responsibility of the unit manager. In the organizational structure there may be a difference in the person to whom the manager reports: the administrator; an assistant to the administrator; the director of nursing; or a nursing supervisor. The responsibility of the unit manager may vary in terms of the number of nursing units, number of patient beds, and the activities and tasks under his supervision.

This report, an appraisal of the SUM concept, is based on a W. K. Kellogg Foundation sponsored two and one-half year study in eight hospitals. Stress has been placed on the evaluation of the SUM concept and on isolating the problems in implementing and operating a service unit management program. The study team analyzed SUM as it existed in study hospitals so that guidelines could be suggested for introducing SUM in a manner to assure maximal acceptance.

The report is weighted to conclusions reached by a multi-disciplinary research team rather than to extensive presentations of statistical data for the reader to analyze. The evaluations are presented in three major chapters written from the perspective of three different disciplines: industrial engineering; organizational science; and social psychology. The principal authors were active in the investigation and all were faculty members of The University of Michigan. In nursing observation studies, registered nurses were used as observers in all instances.

The study consisted of two parts: a national questionnaire survey to identify hospitals with SUM and the characteristics of those units; and a definitive study of eight selected hospitals so there could be a comparability of performance between those with and without SUM.

Fifty-five patient units were investigated in the eight hospitals including 32 units with SUM and 23 without. The patient units studied were restricted to medical, surgical, and medical-surgical.

Three types of hospitals were included in the study: hospitals that did not have SUM on any of their units; hospitals that had SUM throughout; and hospitals with SUM on some units and not on others. In the last category a sample of both SUM and non-SUM units was included in the study.

In the definitive study of each patient unit in the study sample, data were collected for measurements in the following areas:

- Personnel costs
- Quality of care
- Patient work load
- Personnel satisfaction
- Organizational tension and management style
- Personnel acceptance of SUM
- Assignment of responsibility for activities between nursing, SUM, and other departments.
- Type of SUM organization

To supplement the formal data collection, extensive interviews were held with key personnel of all the study hospitals.

An extensive annotated bibliography has been added to provide a current summary of literature on SUM. Many citations from "unpublished" sources were made available through the Cooperative Information Center for Hospital Management Studies, The University of Michigan.

The eight study hospitals included William Beaumont Hospital, Royal Oak, Mich.; Borgess Hospital, Kalamazoo, Mich.; University Hospital, Ann Arbor, Mich.; Toledo Hospital, Toledo, Ohio; Presbyterian-St. Luke's Hospital, Chicago, Ill.; University of Chicago Hospitals and Clinics, Chicago, Ill.; Massachusetts General Hospital, Boston, Mass.; and Peter Bent Brigham Hospital, Boston, Mass.

CHAPTER I.
WHY CONSIDER SUM?*

Hospitals have had a variety of reasons for introducing service unit management (SUM). This chapter will discuss the objectives generally expressed for SUM along with study results which indicate whether the realization of the objectives can be expected, and, if so, under what conditions.

The objectives generally advanced for introducing SUM include:

1. Reduction in cost;
2. Improvement in quality of care;
3. Saving professional nursing time, and thus reducing the nursing shortage;
4. Increasing personnel satisfaction; and
5. Setting a stage for further improvements.

In order to investigate the effect of SUM from the standpoint of each of these objectives, it is necessary to have an understanding of the interrelationships that may exist. Furthermore, it is evident that the presence or absence of SUM is only one organizational factor that determines the nature of performance of the patient care operation. Other factors, such as the staff size and staff mix, the quality of the staff, the equipment and facilities available, and the type of management and supervision may influence the level of performance, and thus the degree to which the objectives can be met.

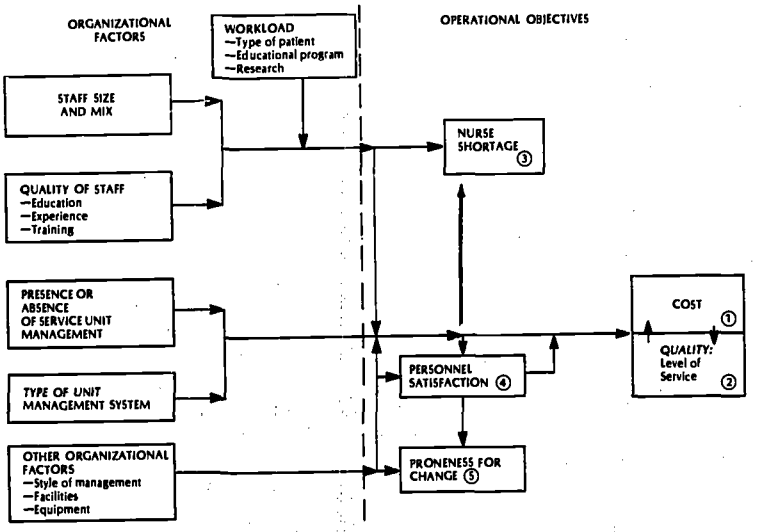
In order to obtain a conceptual understanding of the patient care operation in terms of how the presence or absence of SUM and the other organizational factors may influence the various objectives expressed by the five purposes for introducing SUM, a graphical representation of the situation is illustrated in Figure I-1.

Although this illustration does not show the actual effects, it does provide a framework for discussing the results of the study. The material that follows focuses entirely on the discussion of the effect of SUM on operational objectives and does not present results of the effects of other organizational factors on these objectives. These factors, however, are identified for an obvious but often overlooked reason: any single organizational change repre-

*Richard C. Jelinek, Ph.D., formerly Associate Professor of Hospital Administration and Associate Professor of Industrial Engineering, The University of Michigan, had the primary responsibility for drafting this chapter. Dr. Jelinek is currently Vice President of Medicus Corp.

FIGURE I-1

CONCEPTUAL MODEL OF THE PATIENT CARE OPERATION



Legend: The lines joining the various boxes represent the anticipated relationships with the arrows indicating the direction from the anticipated cause to the effect. All of the organizational factors are causal factors in that they determine the level of performance as expressed by the operational objectives (measures of performance). The boxes associated with the operational objectives are identified by the numbers corresponding to each of the purposes for introducing SUM. This conceptual model for the patient care operation identifies only some of the major factors that characterize the organization and its objectives, and indicates only the major anticipated relationships.

sents only one factor in many that influence performance. Thus, one conclusion of our study: although SUM, in general, is associated with higher performance, if some other set of organizational factors is unfavorable, performance may be low even when SUM is present.

This model is useful as a framework to facilitate a discussion of the effect of SUM on the objectives associated with each objective. Because of the critical nature of the objectives associated with the first two purposes, those of "cost" and "quality," a discussion of the measurements used for them and the observed inter-relationships between them will precede the discussion related to the effect of SUM on them.

COST AND QUALITY FACTORS

Cost and quality of the patient care operation, although representing only a sub-set of all possible objectives regarding performance, are two basic dimensions of performance measurement.

"Cost" is the measure representing the cost of resources associated with the output. In this study, the cost is in terms of personnel resources per patient day and is viewed in two ways: personnel hours per patient day; and personnel cost per patient day. The study also provides for an adjustment for differences in patient conditions by classifying patients on the study units according to the degree of care required, investigating the effect of different classes of patients on need for personnel time, and using this information to create a workload index for each of the patient units. Staff size and cost, besides being compared on a per patient day basis, were also compared on a per workload index basis.

"Quality" is the measure of the level of service provided. Three approaches were used in this study to obtain a measure of quality:

1. the use of a quality index based on sample observations directed toward measuring the presence or absence of certain attributes associated with the quality of patient care;[1]
2. the use of expert judgment by professional nurses who observed the patient care operation; and
3. the perception of nurses working on the patient units as to the quality of care on their units.

The relationship between the "quality" measure and the "cost"

[1] Quality Sampling Instruments, Bureau of Hospital Administration, The University of Michigan, Ann Arbor, 1968.

measure is of utmost importance. It can be argued and, in fact, it has been supported by data from this study, that although investing more money in personnel improves quality, it does so at a decreasing rate.

Experienced administrators will never argue that they have the perfect organization (i.e., the one that gives the last possible increment of quality for every dollar spent). Organizational change, such as introducing SUM can, in fact, improve the overall level of efficiency and thus can raise the level of quality for any given level of personnel (cost). Figure I-2 illustrates a situation where the introduction of SUM improves the efficiency.

In this figure the solid line represents the situation for the non-SUM organization and the dotted line for an SUM set-up. This framework now makes it possible to evaluate the effect of the organizational change without requiring that either cost or quality be held constant. In short, a hospital can use SUM in an attempt:

1. to improve quality and hold costs constant (move from point 0 to A on Figure I-2);
2. to cut costs and hold quality constant (move from point 0 to B);
3. to do a little of both (move from point 0 to C);
4. or even to sustain a small cost increase to make a larger quality improvement (point 0 to D).

It is the last of these that most hospitals introducing SUM use.

This "cost-quality" relationship also points out the need to consider "cost" and "quality" simultaneously when making comparisons of different patient care units. It can be seen from Figure I-2 that a patient unit with a less efficient system (represented by point X) can provide higher quality of care than a patient unit in a more efficient system (represented by point Y) but only at a much higher cost.

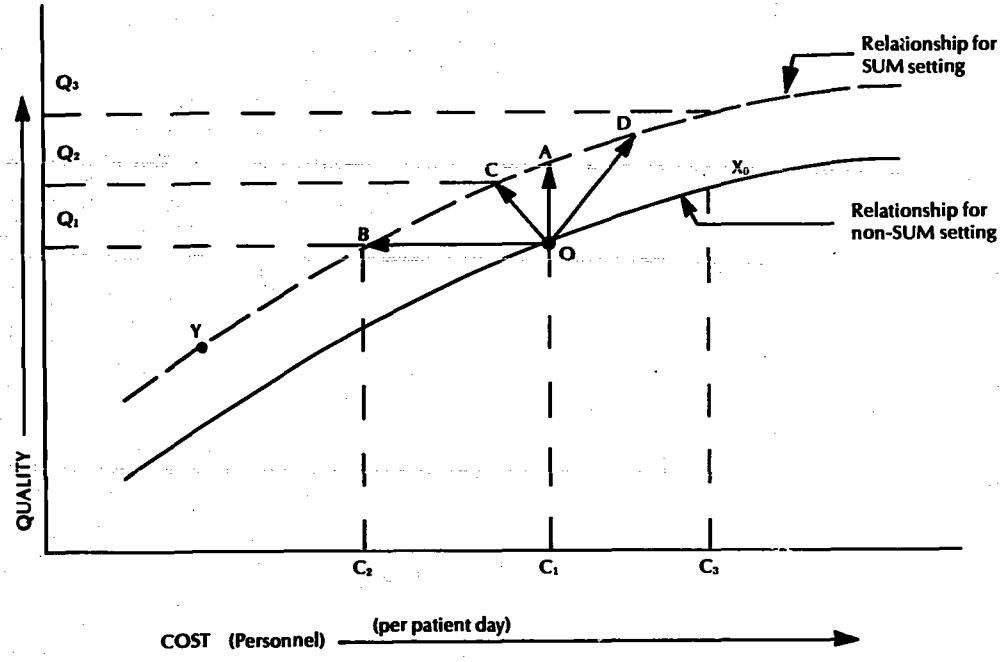
With an understanding of the "cost-quality" relationship, we can now proceed to discuss the arguments that are given to support each of the motives for introducing SUM along with the relevant results of the SUM study as it relates to each such motive.

UNIT MANAGEMENT TO REDUCE COST

1. Arguments in Support of This Purpose
   a. Unit management will relieve the professional nurse of non-professional tasks and assign these tasks to SUM personnel at an appropriately lower skill level associated with a relatively lower wage.

FIGURE I-2

OPERATIONAL INTERPRETATION OF THE "COST" VS. "QUALITY" RELATIONSHIP



b. The unit management staff is expected to function more efficiently than the traditional organization due to a clearer specification of responsibilities and administratively oriented supervision.

2. Results of the Study

There is no evidence that the introduction of SUM reduces personnel cost. Table I-1 summarizes the cost per patient day in the study hospitals.

TABLE I-1
PERSONNEL DOLLAR
COST INDEX PER PATIENT DAY

Hospital	SUM	Non-SUM
1*	7.32	5.12
2	6.18	
3	6.24	
4	3.89	
5	5.86	
6*	7.06	4.71
7		5.99
8		6.43
Average	6.09	5.56

*Hospitals 1 and 6 each had patient units of both SUM and non-SUM type.

Legend: These costs represent personnel costs over a ten hour period which begins at the start of the morning shift and includes week days only. In order to make personnel costs comparable between hospitals, a national average wage is calculated for each personnel category and, furthermore, costs are corrected for any differences in patient conditions. The costs in the table, therefore, should not be viewed as actual dollar cost, but as a cost index which is meaningful in a relative way when interest lies in comparing cost differences between hospitals.

The average personnel cost in all the study hospitals on patient units having SUM is slightly higher than for the units without SUM. It should, however, be pointed out that, because there is a relatively wide range in these costs for both SUM as well as non-SUM units, the difference is not statistically significant.

The fact that actual personnel costs have not been reduced does not provide enough information to conclude that SUM does not have the potential to reduce cost. Cost is a direct result of the number and type of personnel assigned to the unit and not an indication of the unit's efficiency. That is, the same number of personnel could be accomplishing more (providing a higher level of service and thus quality) in the SUM environment.

The absence of cost reduction in the introduction of SUM can be explained at least in part by the fact that none of the study hospitals introducing SUM gave cost reduction as the primary

objective for introducing it. In all cases, the primary objective was either to improve quality of care, or to increase the utilization of professional personnel so as to reduce the problem of staff shortage and not necessarily to reduce the existing staff. Cost reduction was indicated as a secondary objective by most hospitals. In addition, to increase the probability of the success of SUM, there has been a tendency for the hospitals that began the introduction of SUM on some of their patient units to provide these units with higher than average staff levels.

It should also be pointed out that this study has limited itself to evaluating personnel costs on the patient unit and has not evaluated the effect that SUM may have on other costs such as ancillary departments, utilization of supplies and equipment, and administrative costs. There is, however, speculation that many of these other costs will, in fact, be somewhat reduced by the introduction of SUM. This is expected because of the more concentrated effort on the part of the unit manager to deal with other departments and with administrative responsibilities. Under the non-SUM system, the head nurse in charge will consider these responsibilities secondary to the responsibility for patient care.

Consider the reasons given for the belief that SUM will reduce costs.

1. Relieve the Professional Nurse of Non-Professional Activities

The argument is supported in part. The work sampling study which measured the time personnel devoted to various activity categories showed that the professional staff—head nurse (HN), registered nurse (RN), and licensed practical nurse (LPN)—in all the study hospitals devoted somewhat less time in the general category of unit-centered activities[2] and indirect patient care. Both of these categories include a large portion of activities that do not require professional nursing skills. The professional staff also reduced the proportion of its time to personnel-centered activities.[3] This was due to the fact that under SUM the unit manager relieved the head nurse and to some degree the registered nurse, of responsibility for personnel activities as shown in Table I-2.

[2]These include: obtaining, dispensing, and maintaining material for the unit; all housekeeping and dietary activities on the patient unit; messenger service; patient transportation; and other miscellaneous unit centered activities.

[3]Personnel centered activities include: professional staff development; personnel management; and student nursing program.

TABLE I-2
PERCENTAGE OF TIME DEVOTED TO ACTIVITY GROUPS
BY THE PROFESSIONAL STAFF (HN, RN AND LPN)*

	Non-SUM	SUM	Difference between Non-SUM and SUM
Direct Patient Care	26.0%	28.5%	+2.5
Indirect Patient Care	44.8%	43.2%	−1.6
Personnel Centered	4.9%	3.5%	−1.4
Unit Centered	10.2%	9.0%	−1.2
Personal, Unoccupied and Standby	14.1%	15.8%	+1.7

*Head Nurse
Registered Nurse
Licensed Practical Nurse

The data also indicate, however, that the time saved by the SUM system in the unit-centered activities (non-professional) and the personnel-centered activities was not fully utilized by the professionals. There was some increase in direct patient care activity; however, there was also a significant increase in personal, unoccupied, and standby time.

Thus, the study indicates that although the SUM system is effective in relieving the professional nurse of non-professional activities, the professional nurse does not take full advantage of the situation in terms of devoting the time saved to productive professional activities which should be reflected in the time devoted to direct patient care. The study does provide evidence—primarily from interview data—that in the introduction of SUM in all the study hospitals, little attention was placed on the effective reorientation of the professional nurse.

Although the effect of SUM on the proportion of time the professional nurses devote to the various activities has been consistent for all the professional categories, it had a greater impact on the HN than on the RN and LPN. For example, whereas the shift in direct patient care for all professionals has been from 26.0% in non-SUM to 28.5% in SUM, for the HN alone it has shifted from 11.9% to 18.2%.

2. Unit Management Is More Efficient

The argument that unit management is expected to function more efficiently due to a clearer specification of responsibilities and administratively oriented supervision is supported by the study results. Although, as pointed out earlier, the hospitals that introduced SUM did not reduce their cost on a per patient basis (in fact, it was slightly increased), the study results show that under the

SUM system, the level of the service (measured in quality of patient care) increased. The increase in quality is, furthermore, proportionately greater than what it would be by simply increasing the staff in the non-SUM situations to those levels experienced by SUM.

UNIT MANAGEMENT TO IMPROVE THE QUALITY OF CARE

1. Arguments in Support of This Purpose
   a. By releasing professional nursing staff from non-nursing activities the professional staff will have more time available for professional activities and thus will be able to improve the quality of this aspect of patient care.
   b. As argued under the cost motive, the unit management staff, responsible for a clearly defined sub-set of patient unit activities and under administratively oriented supervision (as opposed to a more professionally oriented supervision that a head nurse is likely to give), will perform at higher efficiency and provide better quality.

2. Results of the Study: General Results Regarding Quality

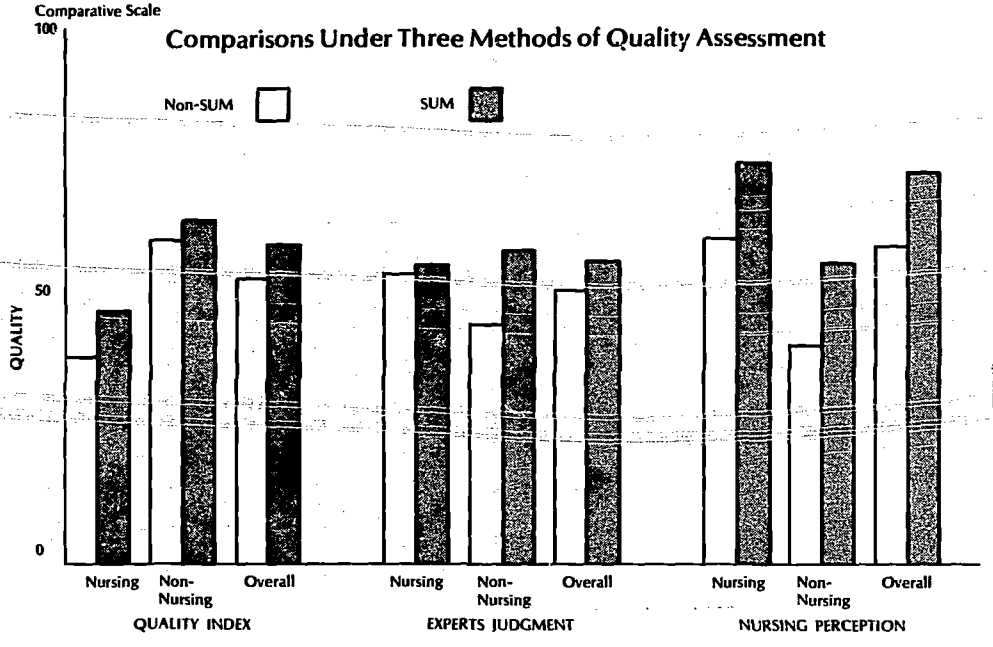
The study results show SUM units in the study hospitals averaged somewhat higher in quality than comparable non-SUM units. This difference was observed in all three techniques used in the study to measure quality: in the quality index; in the expert judgment of professional nurses; as well as in the perception of the nurses on the units. These are illustrated in Figure I-3. The quality measures were scored on a 100 point scale, where the lowest quality patient unit was scored as zero and the highest quality unit as 100.

For each of the techniques used to measure quality the figure presents comparative results for three quality sub-indices. The first of these, quality of nursing tasks, reflects the quality of those tasks for which the nurse is primarily responsible, which include activities dealing with patient welfare and safety, patient comfort, patient chart and nursing care plan. The second index, quality of non-nursing tasks, reflects the quality of non-nursing type tasks, including the cleanliness and appearance of the patient room and patient unit, ward administration, and ward building management. The third index, overall quality, reflects the quality of both nursing and non-nursing tasks. All of the differences are statistically significant.

The results presented in Figure I-3 represent actual averages of the quality measures in all of the study hospitals. Recognizing that the SUM patient units, at an average, have a somewhat higher cost,

FIGURE I-3

EFFECT OF SUM ON QUALITY



and that cost (staff size) itself can influence quality, a further analysis aimed at separating the effects of cost (staff size) and introduction of SUM was conducted. Results of this analysis, presented in Table I-3, may be interpreted as measuring the change in the quality measure that the study hospitals would have experienced if they had kept their cost per patient day constant. This analysis was done using the quality index measure. It represents further evidence that SUM has a favorable effect on quality.

TABLE I-3
DIFFERENCE IN QUALITY INDEX
WITH PERSONNEL COST DIFFERENCES ELIMINATED

	Net Quality Advantage of SUM Over Non-SUM Units
Quality of Nursing Tasks	+4.28*
Quality of Non-Nursing Tasks	+8.47

*A comparative rating scale of 0–100 was used.

Some additional insight into the effects that SUM may have on quality can be obtained when the results of the study are viewed in terms of the two arguments that are generally given in support of SUM to improve quality of care.

a. The argument that quality of professional nursing care will be improved by relieving the professional nurse of non-professional activities is supported only in part by the data. Although the professional staff is relieved of some non-professional activities, its time shifts only in part to the patient centered activities. This conclusion is supported by both the activity study, which shows that only a part of the nurse's relief is devoted to patient care activities (a significant fraction of the relieved time goes into non-productive activities), as well as by the quality study which shows that the quality of nursing tasks under SUM increased only slightly and to a much lesser degree than the quality of the non-nursing tasks (see Table I-3).
b. The second argument for increased quality, that the unit management staff is expected to function more efficiently due to a clearer specification of responsibilities and administratively oriented supervision, is supported by the overall improvement of the effectiveness of the SUM units when viewed in terms of the cost-quality relationship. Although average cost is slightly higher for SUM units, the average quality measures, when corrected for cost (that is equivalent to comparing quality measures for units with same cost) are

significantly higher in the SUM units. This finding indicates that the improvement in quality is more than proportionate to the increase in cost. Thus, the conclusion is that the overall effectiveness of SUM units tends to be higher.

UNIT MANAGEMENT WILL SAVE PROFESSIONAL NURSING TIME AND THUS REDUCE THE NURSING SHORTAGE

1. Argument in Support of This Purpose
   a. Under the traditional form of patient care organization, the professional nurse is responsible for all patient unit activities, both professional and non-professional. Even though nurses' aides may be available to perform many of the non-professional tasks, the professional nurse, being responsible, will find herself devoting much of her time to the non-professional tasks.

2. Results of the Study

The argument that SUM will relieve the nursing shortage is in part supported by the study. As discussed earlier, the SUM system does relieve the nurse of non-professional activities and thus creates a potential for having the existing professional staff function more effectively. In practice, however, the nurse does not appear to take full advantage of this potential. As also pointed out earlier, the lack of a greater improvement in the utilization of the professional nurse appears to be caused by the absence of a reorientation of the professional as well as an absence of clear-cut objectives and goals for the nurse.

The study results indicate that the presence of SUM increases the work satisfaction of the professional nurse. This effect is discussed in the next section dealing with the topic of personnel satisfaction. It is, however, relevant to nursing shortage in that previous studies[4,5] show a relationship between work satisfaction and turnover. Even though the data in this study do not include turnover figures, the fact that more highly satisfied personnel are less likely to leave their job supports the conclusion that, in the long-run, patient units with SUM are likely to have a smaller turnover rate resulting in a smaller professional shortage.

[4] *Modern Technology and Civilization* by Charles R. Walker, published by McGraw-Hill Book Company, Inc., New York, New York, 1962, p. 105.

[5] *Standards for Morale: Cause and Effect in Hospitals* by R. W. Revans, published by Oxford University Press, 1964.

UNIT MANAGEMENT WILL INCREASE PERSONNEL SATISFACTION

1. Arguments in Support of This Purpose
   a. Unit management relieves professional nurses of non-professional tasks which they may consider burdensome and not appropriate for their skill and training, thus making the nurse's job more satisfying.
   b. Unit management personnel have a "spelled-out" function of their own to perform. Their activities, by being under their own control, result in a more satisfying job.
   c. The administratively oriented supervision of personnel responsible for administratively oriented tasks tends to reduce the potential dissatisfaction of such workers when under a professionally oriented supervision.

2. Results of the Study

In the study these arguments were tested in several ways. One of the obvious tests was to determine whether reduction in the number of non-nursing tasks was, in fact, associated with an increase in the satisfaction of nurses. One-hundred-eleven tasks (see Appendix 1) were identified as potentially transferable to non-nursing personnel (SUM or other departments), and the study units were ordered according to the number of tasks which were assigned to nursing. The satisfaction of nursing personnel is highly related to the number of tasks transferred (see Figure I-4).

Beyond a certain point, transfer of additional tasks was not associated with increased nursing satisfaction. This was investigated by comparing the effect of satisfaction of transfer from nursing to (a) SUM, and (b) other departments. The results are illustrated in Figure I-5. They show that the satisfaction continues to increase if the transfer is to SUM, rather than to other departments.

We may summarize this finding as follows. When nurses have many non-professional tasks, they do not care who gets them, so long as they get rid of them. Beyond that point, they prefer having the on-unit, non-professional tasks performed by a single responsible department. The results of the research thus support the first argument in favor of SUM, but with the qualification that merely getting rid of tasks is not the only issue; the tasks must go to a department that does not cause other difficulties.

This qualification is an interesting one, and helps illuminate another finding. SUM is better from the nurses' point of view if it results in increased clarity in who is responsible for what. If the transfer of tasks is accompanied by an increase in confusion, as it

FIGURE 1-4

RELATIONSHIP BETWEEN NON-NURSING TASKS TRANSFERRED FROM NURSING AND NURSING SATISFACTION

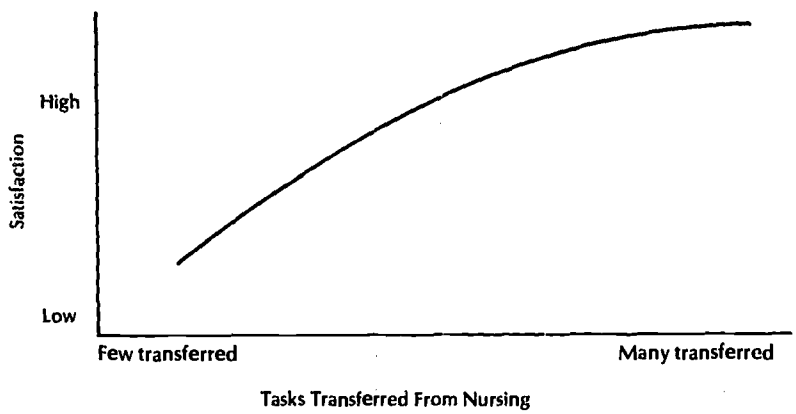
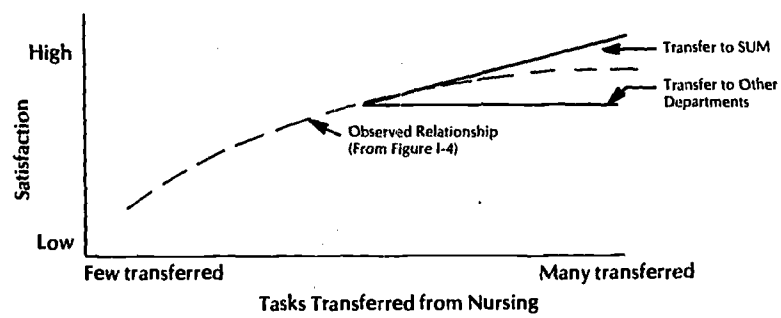


FIGURE 1-5

NURSE SATISFACTION AS IT VARIES WITH TASK TRANSFER TO SUM OR OTHER DEPARTMENTS



sometimes is, satisfaction may not increase. It is not only the transfer of tasks, but clear understanding of "who is responsible" that leads to increased nursing satisfaction. As the disorganization and tension that accompanied unclear division of responsibility increased, so did nursing dissatisfaction.

Fortunately, SUM can help clarify responsibilities, a point which is clear from the higher nurse satisfaction when tasks were performed by SUM, rather than by outside departments. Non-professional personnel, including nurses' aides, ward clerks, maids, porters and dietary aides, also experience greater satisfaction with unit management, as is illustrated in Figure I-6.

It is difficult to know exactly what the reasons for this are, although interviews did confirm the greater satisfaction which arose from being in a structure focused on a patient unit, rather than on a functional service. As compared with housekeeping, dietary, and other non-professionals, unit management personnel spent more time talking with each other on work-related matters, and less time on non-related matters (personal affairs, etc.). They also experienced more supportive, and less critical communication from those they worked with than did non -professionals on units without SUM.

Non-professionals liked unit management better, though Figure I-6 suggests that they remained somewhat less than satisfied. Similarly, there is nothing in our data to suggest the abilities of non-professionals were well utilized under SUM, although the somewhat better utilization was associated with the higher satisfaction.

In summary, the results of the study indicate that patient units on which SUM has been introduced have more satisfied personnel than non-SUM units. Obviously, other factors than SUM affect the satisfaction of personnel, but our interest here is not the general question of what determines satisfaction, but how SUM affects it. Clearly, the effect is positive.

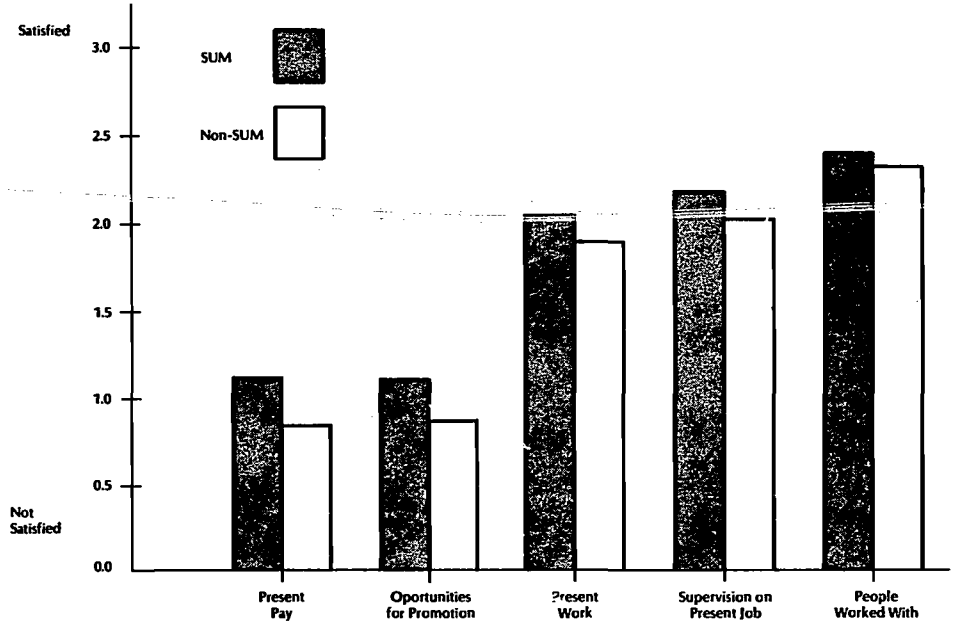
UNIT MANAGEMENT TO SET THE STAGE FOR FURTHER IMPROVEMENT

1. Argument in Suport of the Purpose

Many hospital and nursing administrators envision major organizational changes on the patient units in the years ahead. However, at this point they only see the direction in which the change is to take place, without a clear model of the eventual organizational form. Furthermore, they recognize that implementing major changes, especially changes that affect the roles of a great many

FIGURE I-6

SATISFACTION OF NON-PROFESSIONAL PERSONNEL
WITH DIFFERENT ASPECTS OF WORK



individuals, requires caution and time. They see the introduction of SUM as a first feasible step toward a possible major reorganization, one which is in the right direction and from which it may be possible to learn how to proceed further.

2. Results of the Study

Although results related to this purpose have been obtained from interviews with individuals in the study hospitals and general personal observations rather than any hard data, there has been enough general consensus to draw a number of conclusions. Unit management is a concrete approach to bring administration closer to the patient unit function and to allocate tasks more appropriately to skill levels. The form in which it is implemented is frequently only a short step toward what can be accomplished in the reorganization of patient care activities. It is, however, a feasible step; one that can be "bought" by both nursing and administration. By introducing this step, nursing as well as administration is forced to take a closer look at what is going on in the patient care function, thus bringing to the surface many of the real problems and issues. This sets the stage for additional changes, possibly changes with even greater impact than that of unit management per se. There appear to be four general possibilities: reconceptualization of nursing; changes in the ancillary departments; decentralization of clerical and other administrative activities; and decentralization of policymaking (bringing patient care unit policy-making closer to the unit). A discussion of these possibilities is included in Chapter III.

It is of interest to note that none of the study hospitals initiated unit management with any of the above consequences as an objective, with the possible exception of the first, reconceptualizing nursing. The unit management concept was relatively new and the total possible impact had not been seen. However, given the publicity of experiences with successful programs, it is expected that some hospitals will see unit management as a means to some of the above objectives. All hospitals in the study at some point began to study the nursing problem and many were becoming aware of the ancillary department problem. Two hospitals were aware of the potential for the decentralization of some activities and were looking into it and at least one was planning decentralized policy-making.

CHAPTER II. WHAT KIND OF UNIT MANAGEMENT?*

INTRODUCTION

Chapter I has described the hoped-for results of SUM, and the actual results as found in the eight study hospitals. This chapter will assume the reader has decided in favor of unit management and wishes to learn more about what it really is. It has not been adopted equally by hospitals of all sizes, as Table II-1 below shows. In general, small hospitals have not considered it, and teaching hospitals are among the most likely to introduce it, especially university centers.

TABLE II-1
Distribution of Hospitals by Size, All Hospitals and Those with Unit Management

	All Hospitals* N=7,137	Hospitals with SUM** N=133
Under 100 beds	53%	1%
100–199 beds	20%	7%
200–299 beds	9%	14%
300–399 beds	6%	19%
400–499 beds	3%	21%
Over 500 beds	9%	38%
	100%	100%

*_Hospitals_, Journal of the American Hospital Association, Part Two, Volume 43, Number 15, August 1, 1969, p. 494.
**1969 Survey, Bureau of Hospital Administration, The University of Michigan.

More than size of hospital, however, should be considered in the decision to introduce a unit management program, for the purposes to be achieved should determine the kind of SUM a hospital will introduce. "What kind" of unit management really means three things:

1. The jobs of unit management: what *tasks* will be transfered to the unit manager and his subordinates;
2. The focus of unit management: what balance will be established between the three *orientations* of strengthening administrative control and services, serving nursing, or improving the nonclinical aspects of patient care;

*Fred Munson, Ph.D., Associate Professor of Hospital Administration, The University of Michigan, had the primary responsibility for drafting this chapter.

3. Organization structure: what kind of *reporting* and *authority relations* will be established for unit managers.

These three areas can and do have great variation in different SUM programs. Each will be considered in turn.

JOBS OF UNIT MANAGEMENT

There is some tendency to think of unit management only as a method of relieving nurses of non-nursing tasks, and turning such tasks over to unit management. This is not a complete description of what unit management programs include, although it is the way many programs start. There are seven different categories of tasks that can be made a part of the unit management department.[1] These are shown in Table II-2.

TABLE II-2
Categories of Tasks Performed by a Unit Management Department

— Logistic and Clerical
  1) Handling supplies, equipment, and contacts with maintenance,
  2) Traditional ward clerk activities,
  3) Transcription of MD orders,

— Patient Support
  4) Patient transportation and messenger service,
  5) On-unit housekeeping and dietary functions,
  6) Non-professional direct patient care,

— Administrative
  7) Admitting, accounting, central supply activities that can be done more efficiently on the unit.

A listing of these categories of tasks suggests that there are both activities and responsibilities that can be shifted. It is important to keep these two ideas separate. Shifting activities simply gives the nurse an extra set of hands. The addition of a ward clerk or a transporter to the nursing unit relieves nurses of maintaining records and moving patients, but does not relieve them of the responsibility for accurate records or of having patients at their appointments on time. Developments prior to unit management indicate that many nursing activities had already been transferred to other personnel.

[1] See the Activities List in Appendix 1 for the way used to get a measure of what activities had been given to unit management in the study hospitals.

Initially, SUM is often defined in negative terms, e.g., it is what something else *is not*. Thus SUM is to handle non-nursing tasks, or SUM is to be responsible for non-therapeutic management, etc. This is a residual concept of SUM, and the concept is a prominent one. In spite of polite verbiage, it usually means that SUM is to handle someone else's unwanted activities, rather than accepting significant responsibilities of its own. Though this is not a fortunate way to start a SUM program, one should recognize that shifting responsibilities is far more difficult than shifting activities. Responsibilities cannot be shifted until it is possible to define purpose with some precision, and this has been a continuing problem for the nursing profession. Probably the only reasonable way to start in the case of nursing was by subtraction, defining what was not nursing, rather than what was. Naturally, the first and most important shifts of responsibilities were for relatively low-level and time consuming chores in nursing; those most distant from patient care.

1. Supplies, Equipment, and Maintenance

In the survey done in late 1969, over 98% of the 133 hospitals reporting a unit management program indicated that unit management had relieved nurses of activities in this area, such as: ordering and securing equipment from various departments, cleaning and returning it; ordering and storing regular and special supplies; identifying the need and requesting such things as wall washing, painting, equipment or plumbing repair and insuring completion of such work. (See Table II-1.) This category of activities also contains some potential problems for unit managers, since a maintenance or central supply supervisor may not like having his communications cut off with nursing. In several of the study hospitals this had been a serious problem, and remained so in one hospital two years after the program began. The head of that program described the problem: "Of our two functions, supervision of personnel and coordination of services to the patient unit, it is the coordination which presents the more serious problem. Housekeeping and maintenance personnel in particular give us problems. . . . We will put in a requisition for something, and we will never hear about it, much less get it done. Then the Director of Nursing will call down to maintenance: 'can we get that room painted?' and the painters will be up right away."

2. Traditional Ward Clerk Activities

Eighty-nine percent of the hospitals in the survey had transferred to unit management such activities as answering phones, greeting

visitors, making appointments, assembling patient records, arranging transport, and so forth. Unlike much of the supplies and maintenance activities, these duties had already been assigned to a non-nursing position, the ward clerk or secretary. This is a transfer of responsibilities for ward clerk supervision, rather than a simple transfer of activities.

Many ward clerks have developed rather close relations with "their" head nurse, and do not like the idea of a new boss. A unit manager in one of the study hospitals pointed out that one of her ward secretaries had been trained by the head nurse, had worked only with her, and that, "She can't distinguish between her duties as ward secretary and the favors she does for the head nurse. They know each others' thoughts, almost." Not surprisingly, such relations cause problems for the unit manager.

SUM often includes stewardess functions

The ward clerk position developed under the head nurse because it is with this position that the ward clerk had most contact. A mere transfer of the position to the unit management table of organization will not by itself change the information flows, most of which arise from work-related needs and spatial relations, rather than the organization structure. Thus, the ward clerk may remain in close contact with nurses and, if the unit manager does not know how to perform the activities of the clerk, there may be difficulty in convincing either the clerk or the nurses that the transfer of responsibility for these activities from nursing to unit management has taken place anywhere except on paper. Good training programs for unit managers can avoid many problems here.

3. Transcribing Doctor's Orders

A third area of responsibility which 76% of the survey hospitals had transferred to SUM was the transcription of physician orders. In one of the study hospitals, this transfer of responsibility was reflected in a separate responsibility statement, which indicated in detail the division of activities between the unit management and nursing department. Portions of the statement are reproduced in Table II-3.

Nurse resistance to having non-professionals transcribe physician orders is well-known. Although some nurse resistance is only a reflection of physician resistance to contact with anyone but the nurse in matters concerning care of their patients, this cause is less important than the feeling of some nurses that this essentially clerical chore is, nevertheless, high-status work.

The transfer of this task of transcription usually comes in stages. In one study hospital, the process of shifting responsibility took about three months in the initial units. The steps included securing nursing agreement to the "experiment" while training the ward clerk to transcribe orders, introducing it under close nursing supervision followed by more general supervision until, finally, a complete shift of responsibility occurred. In the hospital from which the responsibility statement on page 36 was taken, nursing was still responsible for key transcriptions, although the activity had been transferred to unit management.[2]

Activities in these three areas (supplies and maintenance, ward clerk work, order transcription) are the ones most commonly

[2]See Nursing Activity (4), Table II-3.

transferred to unit management, and are also the ones that come directly from the nursing department. Though other reasons can be and are given for the transfer, it is clear that relief of nursing is a central idea behind the transfer of these activities and the responsibility for them.

A group of activities more clearly separated from nursing can also be included in the unit management department. Many of these are associated with the hotel-like attributes of a hospital, with food, laundry, housekeeping, or escort services. In some hospitals, and indeed in one of the study hospitals, many of these activities were performed within the nursing department until the establishment of SUM. In such cases, the unit management aide may be in part a direct replacement of the nurse aide. These activities are often performed by some of the least skilled of hospital personnel, and require close and continuing supervision with SUM.

TABLE II-3
Responsibility Statement
—Support to Physician—

	BY UNIT MANAGEMENT	BY NURSING DEPARTMENT
Unit Clerk	1. Provide physician with chart and records	1. Make rounds with the physician
Unit Clerk	2. Call diagnostic departments for information at the request of the doctor	2. Assist physician with procedure
Unit Clerk	3. Transcribe all of the physicians' orders	3. Confer with the physician as to plans for present and future care of patient
Unit Clerk	4. Perform all clerical activities needed to carry out the physicians' orders	4. Verify and countersign transcription of orders for medications and treatments using medication
Unit Manager	5. Confer with physician regarding non-nursing aspects of patients' care	5. Integrate nursing care with medical care plan
Unit Clerk	6. Notify physician when his services are needed to administer medications for diagnostic tests and/or to obtain certain specimens	6. Record physicians' verbal order on Doctor's Order Form

Courtesy of William Beaumont Hospital
Royal Oak, Michigan

4. Patient Transportation

Thirty-one percent of the surveyed hospitals had transferred patient transportation to SUM. This is a patient care activity, but in many hospitals it had already been established as a separate service, occasionally outside of the nursing department. In these cases, the unit may be placed administratively under SUM, and there is little reorganization of activities. Two of the study hospitals had such an arrangement, with personnel assigned to a section serving all patient units, and, therefore, reporting to the head of unit management rather than to individual unit managers.

The patient transportation activity is sometimes combined with a dispatch or messenger service to provide a greater workload that is subject to less fluctuation, and also to cut away from more highly paid personnel an activity that requires only a knowledge of hospital department locations. From one point of view, patient transportation requires little more. However, from the patient's point of view, the trip to the operating room, for example, may require the strongest psychological support. Not surprisingly, patient transportation remains in many hospitals a support service, to be drawn on by nursing when appropriate. In these cases, it is not possible to transfer from nursing the responsibility for moving patients, though much of the activity may be transferred. This fact has helped keep patient transportation within nursing in 28% of the 133 survey hospitals. It is in a separate department in 41%, and in the remaining 31% it is in SUM.

5. Housekeeping and Dietary

The transfer of housekeeping and dietary activities to SUM represents a clear shift away from the negatively defined "relieve nursing" posture for SUM to a posture which approaches a definable responsibility for the operation of the patient unit. Activities may be transferred from either or both housekeeping and dietary, but the more common one is housekeeping. Such activities as cleaning patients' rooms and baths, utility rooms, corridors, treatment rooms, securing housekeeping and laundry supplies, making unoccupied beds, and preparing empty rooms can be transferred to unit management. Activities in these areas were being performed by unit management personnel in 17% of the hospitals surveyed. Activities concerned with feeding of patients, by contrast, were only under SUM in 11% of the 133 hospitals. These proportions were somewhat higher in an earlier survey; in spite of this, it appears likely that these activities will increase as unit management becomes more firmly established.

One of the early unit management installations made housekeeping and dietary functions the core of its program, believing that patient care would improve by having on-unit supervision of non-professional personnel performing activities on the unit. It solved the problem of economic use of personnel in part by combining the functions of tray server and housekeeping maid in a single person, and adding other non-critical functions performed by nursing personnel. In a much later installation, this concept was carried farther in the establishment of the stewardess position. The summary of activities in the stewardess job description, given below, suggests how far this hospital has gone in returning the performance of patient-related activities to a unit-centered structure.

> Stewardess: A Job Description
> Performs a variety of service activities. Assists unit clerk in completing unit activities required to admit, transfer, and discharge patients. Distributes and assists patients in completing selective menus. Collects menus at designated time. Prepares patient's room for meals. Delivers trays to patients and returns tray to dish return. Passes water and nourishments. Performs all housekeeping activities in patient's room. Makes unoccupied beds. Performs related duties as assigned. (Courtesy William Beaumont Hospital, Royal Oak, Michigan)

6. Non-professional Direct Patient Care

It is evident that the initial and still dominant posture of SUM, to relieve nursing, can move naturally to a quite different one, to serve the patient. Although anything which happens to a patient in a hospital can be therapeutically relevant, there is growing acceptance of the idea that the delivery of some services does not require professional qualifications or direct nursing supervision. These may include guest courtesies such as welcoming the patient to the unit; explaining food service and other procedures; taking care of patient valuables; informing discharged patients of belongings left in the hospital; handling all problems connected with charges, room services or dietary service; handling contact with the patient's family; in short, responding to the reality that a hospitalized person is an institutional guest as well as a patient. The therapeutic relevance of patient comfort and satisfaction does not mean that only the attending physician or on-duty nurse can be responsible for providing for them. Seventeen percent of the surveyed SUM hospitals had transferred non-professional direct patient care responsibilities to SUM.

When unit management takes over such activities, unit management personnel are inevitably brought into close and meaningful contact with patients. This in itself may be objectionable to nurses. There are nurses who feel that the patient is the property of the physician, whom he has left in the nurse's care and no one else's. Even if this extreme attitude is absent, when unit management personnel respond to the responsibility by becoming strongly oriented to a "serve the patient" rather than a "serve nursing" concept of their jobs, conflict can arise. Consider the potential for conflict in the hospital where the director of nursing had these things to say about the practice of nursing:

> You simply cannot define nursing in terms of categories of activities. The focus on the patient will mean that sometimes this will be performed by a professional nurse, at other times it will not. An example of one of the great difficulties with this categorization is that nurses now don't consider feeding the patient a part of the nursing function. This is criminal. Food is most important to a patient. Here is a perfect entree for effective nursing care that has been given up by nursing and is no longer even considered a part of the activity. Other examples are bathing the patient and taking care of the bedpans. These are not necessarily activities that would always be done by a nurse but they are a part of patient care which is the focus of the nursing function.

In another hospital, the director of nursing was eager to have unit management established so that ward helpers, then under nursing, could be transferred to them. She worried that they were getting too close to the patient! Under unit management this could be more easily controlled. In such a hospital, the addition of non-professional patient care functions to SUM will be even more difficult, for the emphasis goes beyond the nurses' full responsibility for patient care, to the nursing department's exclusive right to that responsibility. Should unit management become the channel through which patient complaints reach higher levels, not only about cold food but about poor nursing or medical care, the problem can become explosive.

We must recognize that although SUM often begins as a residual concept, handling nursing's unwanted tasks, it nevertheless becomes a rather well-defined set of activities and responsibilities. In fact, the residual is what is left with nursing, and that is not well defined. Thus when unit management begins to move toward non-professional direct patient care, the question of what the nursing residual really contains becomes for some nurses a genuinely

threatening question. This is a key explanation of the need for a new nursing model.

The provision of non-professional direct patient care is a natural and significant extension of unit management, and viewed in the context of efficient delivery of health care, a sound one. The problem indicated above can be dealt with efficiently, as is evidenced by some hospitals which have built their unit management program around the idea of providing top quality "hotel-like" care to patients.

7. Admitting, Accounting, and Other Administrative Responsibilities

It is less easy to provide illustrations in this category of activities because it is in this area that there is the greatest underdeveloped potential. When units were managed by nursing professionals, it was natural for them to think of service improvement in a nursing other than managerial context. By contrast, a unit manager does not have the responsibility for patient care, and can be expected to think of service improvement in terms of simplified admitting or supplies requisitioning procedures, optimal inventory levels, more effective utilization of budgets as management tools, and, in time, to be pressing for the right to make managerial decisions which are usually enmeshed in red tape and needless communication when made elsewhere.

Physicians, nurses, and other patient care personnel should not need to be concerned with management and administrative problems. The presence of strong management skills on the patient unit presents opportunities for coordinating patient care services that are not present without such skills. Two of the study hospitals had begun to move in this direction; not surprisingly, both were hiring well-educated persons for the unit manager position.

The seven categories of activities described indicate how varied the content of a unit management program can be. This report does not describe only two kinds of hospitals, those with and those without unit management; rather, it describes a pattern of organization that goes from partial transfer of non-professional tasks from the nursing department to another department, to a pattern of thorough restructuring of individual roles and organizational responsibilities within the patient care process.

It became clear during the research that for many people within the hospital, this pattern was characterized not by who did what but by the answer to the question, "Whom does unit management serve?"

THE FOCUS OF UNIT MANAGEMENT

There were clear differences between unit management programs that were oriented to the needs of nursing and those that went beyond this to acceptance of significant responsibility for serving the patient, or for bringing administration to the unit. These differences were in attitudes, in the orientation which key personnel had to the purpose of unit management.

1. Serve Nursing

First, unit management can serve nursing. This is a clear, unequivocal purpose, and one which was dominant in early installations of SUM as, for example, in Sinai Hospital in Baltimore. Sinai saw the importance of relieving nursing of non-nursing tasks and relieving it of responsibility for those tasks. The nature of specialization in the hospital was such that some of the relief of responsibility would have to be achieved by reorganizing other tasks than those presently in the nursing department. The Sinai group was aware that in another hospital the problem of coordination was simply transferred to unit management, without analysis of why the coordination of tasks of various departments serving the patient unit represented so challenging a problem. As it expressed it: "Previously, nursing had struggled with the problems and, ultimately, had somehow found the answers, now the central administrative staff of the hospital was receiving the problems but was not prepared to cope with them."[3]

Unit management could not relieve nursing by accepting problems SUM could not solve, for the problems simply came back to nursing. The coordinative problem itself had to be faced.

The point of "relieve nursing" is central. The Sinai pattern was nursing-centered, with the primary function of the floor manager to be to the nurse what the nurse was to the doctor, able to accept comfortably a lower status than a professional nurse. This did not mean that the unit had to be a part of nursing, only that it had to orient itself toward the needs of nursing.

The advantage of a "serve nursing" orientation is the strong support it generates among nurses for SUM. This support is important in the introductory period because of the close interaction of nursing and unit management personnel. It has several disadvan-

[3] *A Floor-Manager Pattern for the Nursing Unit* by Gladstein, Prasatek, and Throne, published by Sinai Hospital of Baltimore, Inc., Baltimore, Maryland, February, 1959, p. 10.

tages, the most notable being the difficulty it creates in defining anything but a "freeing the nurse to nurse" residual concept of SUM which makes the attraction and retention of competent people difficult. The low status of SUM resulting from a "serve nursing" orientation also makes inter-department requests and other action-demanding communication difficult.

2. Bring Administration to the Unit

Another possible orientation of SUM is: bring hospital administration to the patient unit. This does not exclude activities which serve nursing, but it includes additional activities as well. The key difference here is not what is being done, but why it is being done. The essence of this orientation is not to find activities the nurse does not need to do but to manage a facility in which nurses and physicians practice. The impetus may still come from nursing, but in this case it is likely to be coming from the office of an insightful director of *nursing*, not from the pressures of overwork. This was a key source of the idea in two of the study hospitals, where the determination to re-integrate nursing practice and teaching in a professional role made the necessity of someone else managing the unit very clear.

In these models, nursing is not "served" by unit management, any more than doctors are served by it, or by nursing. All, of course, serve the patient, but the unit manager represents hospital administration and is intended to bring administration to the patient unit and carry full responsibility for that segment of the patient care process. Such hospitals must reject the selection criterion of a "quiet, self-effacing person" for the unit manager as inappropriate. Their pattern of organization places heavy emphasis on true cooperation at the ward level (not using that word in its common distortion, the demand of a superior that he receive "cooperation" from his subordinates).

One can predict initial difficulties with nurses in such a pattern, and many appeared in the study hospitals. As shown in Chapter III, successful management of this conflict is among the most difficult and complex tasks in the introduction of unit management. Nurses were less satisfied when unit management had a "serve administration" than when it had a "serve nursing" orientation. Nurses were less clear about the unit manager role, and there was more tension on the unit, notably between nursing and SUM personnel. Nevertheless, the "bring administration to the unit" theme was associated with higher quality of care, and there was some indication that problems of tension, role clarity, and dissatisfaction were tran-

sitional rather than permanent. The "administration" theme was in the study team's view a more viable orientation than the "serve nursing" theme.

3. Serve the Patient

The third possible orientation is "serve the patient." In a hospital the patient-serving orientation is a highly legitimate one, and has a natural appeal to personnel who occupy low-status jobs but who nevertheless want meaning in their work. A "serve the patient" orientation cannot be attacked directly, but often nurses will not accept that improved patient service should be done by other means than giving the nurse more time to provide it. The exception to this is a situation where nursing has been able to define the practice of nursing as something other than total patient care at all times for all patients minus the physician input, and at present such situations seem to be uncommon. Where nursing has provided a meaningful role for non-professionals, a "serve the patient" orientation is desirable for the unit aide or stewardess level, since it provides a high degree of fit between their purposes and the organizational goals of satisfying, as well as medically excellent, patient care. Needless to say, a "serve the patient" orientation in SUM was associated with a lower nurse satisfaction than a "serve nursing" orientation.

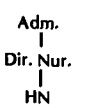
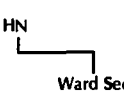
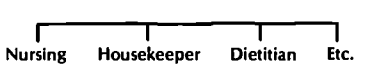
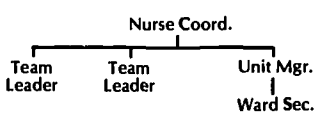
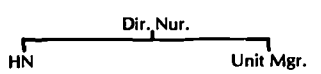
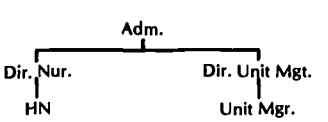
The three orientations of "serve nursing," "bring administration to the unit," and "serve the patient" are really concepts of purpose that are in the minds of participants. The most important is the one in the minds of SUM personnel for it is their definition that will control their behavior in choice situations.

We have talked of the three different orientations separately to emphasize their significance. They are not mutually exclusive, and although one can often be identified as most prominent, it is characteristic of strong unit management programs for at least two of them to be present. In formal statements, of course, all programs will be described as having all three purposes with service to patients leading the list. One must study a program in operation to identify the actual orientations. This point is important: the orientation that develops cannot be legislated, for it flows from decisions about activities transferred, responsibilities assigned, the calibre of unit management personnel, and reporting relations which are established. It is pointless to tell unit managers to have one orientation if the crucial decisions force them into a different one. If a hospital wishes one orientation to dominate, it must reinforce its wishes with actions.

ORGANIZATION STRUCTURE

There are three vital choices which must be made after a hospital has determined what goals it wishes to achieve through the introduction of unit management. We have identified two, the activities which will go to unit management and the orientation which unit management personnel will be encouraged to accept. The third choice concerns the structure of reporting relations. The charts below suggest the alternatives which may be considered in assigning the responsibility for unit activities.

TABLE II-4
Who Will Manage Unit Activities?

Models		
1.		1. Management of activities by head nurse (historical organization).
2.		2. Head nurse delegates some to ward secretary (1940's type organization).
3.		3. Functions integrated by type (housekeeping, dietary, transportation, etc.) and disintegrated on patient units (typical current organization).
4.		4. Key structural unit is enlarged, for example from 20–30 beds to 60–100 beds, and head nurse is given subordinate manager.
5.		5. Unit management activities are retained in the nursing department but removed from head nurse responsibility.
6.		6. Unit management activities are made a responsibility of administration.

As the charts indicate, "unit management" is evolutionary rather than revolutionary. It is another step in the continuing effort to find the best compromise between grouping all activities of a single area under one person, and grouping all activities of a single type under one person. Unit management seeks to avoid the fractionating of patient unit activities which characterizes typical current practices, but to do it without making the head nurse more manager than nurse. (See Table II-4)

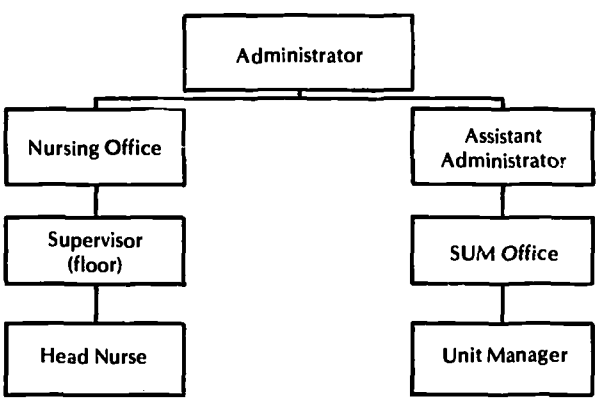
1. Relation to Head Nurse

A critical question must be answered in designing the structure: How close organizationally should the unit manager be to the head nurse? Look again at the three last organization charts, and it will be clear that unit management in the sixth chart is "farthest" from the head nurse, and in the fourth chart "closest" to her. In fact, only the last two are common among hospitals surveyed in 1969, for the fourth one implies a restructuring of the nursing department which is quite unusual. Readers will note that it is a restructuring that gives the nurse coordinator explicit and major managerial responsibility. Of the 133 surveyed hospitals, 38% had placed the unit management program under nursing (Model 5), 62% under administration (Model 6). Typical organization structures are shown in the inset in Table II-5 with type "A" representing the administrative control and type "B" the nursing control structure.

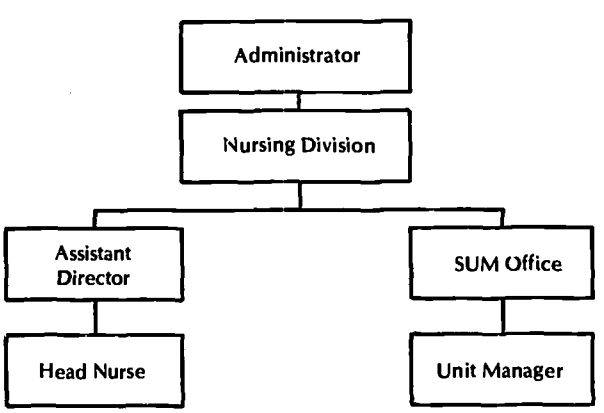
Although it is obvious that having SUM under nursing shortens the formal communication lines between head nurse and unit manager, it also leaves the unit management function within nursing. This was the dominant pattern in early programs. When SUM was introduced, it came because nursing wanted to have someone other than nurses do and be responsible for certain non-nursing activities. In one university hospital, an administrator saw the value of SUM and agreed to take it in administration when nursing chose not to assume responsibility. In another teaching hospital, a nursing administrator was eager to introduce SUM, but failed to convince administration that it belonged with it. Unit management, in the view of nurses, was to take over tasks that were either scut work or frustration producing "coordinating" activities. Nurses had those tasks for two reasons. Nurses had nurse aides, but doctors had nurses. Doctors could pass on duties to nurses, but nurses had to keep their own dirty work in the department—unless they could establish another one. Both nursing and administration put up stout defenses to keep unit management out of their own

TABLE I-5
Administration and Nursing Structure for SUM

HOSPITAL "A"
Manager Supervises 100 beds
Span: Covers one floor, two or three units



HOSPITAL "B"
Manager Supervises 40 beds
Span: One unit



domain. Reasons given were, of course, quite respectable; administration saying so important and significant a step would need the full support of nursing and nursing saying that this managerial program needed the guidance of experienced administrators.

In later installations a more rational approach has become common. In essence, if SUM is to have a "serve nursing" orientation, it makes sense to keep it in nursing. If it is to be an arm of administration, it should be made a part of administration. The tendency in most hospitals has been to see it in this latter light, and fully two-thirds of recent installations have placed the program under administration. It is generally true that in programs under nursing, the unit manager's education and status are lower than in type "A" programs.

The location of the program also has an effect on the activities assigned to SUM. Complete transfer of responsibility for transcribing physicians' orders was done in 56% of the programs under nursing, but in 66% of the programs not under nursing. In general, there is more complete transfer of tasks in all categories for programs not under nursing and fewer instances of SUM and nursing sharing responsibility. This is evident in Table II-6.

TABLE II-6
Patient Unit Activity Responsibility in SUM Hospitals*

	SUM Within Nursing Service		Independent of Nursing	
	SUM Only	Nursing and SUM	SUM Only	Nursing and SUM
Supplies and Maintenance	96%	4%	95%	1%
Ward Clerk Activities	69%	12%	92%	1%
Transcribing MD Orders	56%	17%	66%	11%
Patient Transportation	13%	11%	26%	4%
On-unit Housekeeping Functions	10%	0	14%	1%
Non-professional Patient Care	11%	0	10%	4%
On-unit Dietary Functions	4%	2%	4%	5%

*Analysis based on 133 hospitals responding to 1969 survey.

2. Formal Hierarchy

It is wrong to associate too much importance to organization structure, but it is equally foolish to assume it is unimportant. Whether unit management is under nursing or administration will affect the ease with which nursing-SUM conflicts and SUM-ancil-

lary department conflicts are resolved. Perhaps a matter of equal importance is the actual length of the channel through which formal communications must pass. In one of the study hospitals, the formal channel from nurse to clerk went up through head nurse—nurse supervisor—director of nursing—associate administrator—administrator, and then down another path of equal length to reach the ward clerk. The absence of formal committee structures to by-pass the hierarchy (such committees had been planned) meant that the hierarchy, though necessary for other purposes, was irrelevant at best and commonly a hinderance to the achievement of nursing-SUM coordination. It is important to remember that an organization structure has the purpose of limiting communication to that which is necessary for achieving organizational purpose. If the communication channels necessary for effective performance are unrecognized, the resulting structure will be just one more problem that persons in the organization have to overcome. This is the reason that a number of hospitals (University of Kentucky, Duke University, University of Florida, and Evanston) have experimented with various methods of devising an explicit structure for resolving problems at the unit, or floor level. These efforts are relevant to a range of issues that go well beyond unit management. For our purposes, it is necessary only to recognize that the segregation of unit management activities in a single department can lead to serious communication problems unless steps are taken to overcome them.

3. What is the "Unit?"

One element of the decision concerning appropriate structure is the definition of a unit manager's "unit." In over half of the survey hospitals, it was more than a single patient unit, in a few cases going as high as five or six units and over 150 beds. The more typical manager had about six subordinates, two or three units, and about 80 beds. In the largest single type, the unit manager was responsible for one patient unit, with the obvious advantages of being in a directly parallel structure to nursing, and in a situation permitting close supervision of unit personnel.

The inherent advantages of having parallel structures in nursing and unit management are clear, but the possibility of enjoying them depends on: the size of the patient unit—is it big enough to require a unit manager?; on the activities assigned to unit management—are there enough to require a unit manager?; and on the interest in establishing an administrative orientation—is the job big enough to attract a competent person? The activities in

unit management and the desired orientation are variables, but the size of the patient unit may well be fixed until a new hospital is built. In other words, this aspect of organization structure may well be a function of architecture, rather than management choice. It is probably true that, with the transfer of unit management activities to unit managers the optimal size of patient units will increase, but the question of patient unit size again takes us beyond our focus on SUM. It raises broader questions than simply the management of the unit.

Establishing effective communication with other departments than nursing is a key problem in many unit management programs. It is more serious in type "B" structures because placing SUM under nursing does nothing to change the basic departmental relations. When it is under administration, the assistant or associate administrator responsible for ancillary and service departments is often in charge of SUM as well. In such cases, it is easier to bring into the open the underlying attitudes, incapacity, or conflicting purposes that create the lack of coordination. Simply bringing problems into the open may not solve them, as two of the study hospitals discovered. In most cases, unit managers interviewed indicated that achievement of tasks requiring the cooperation of one or more departments presented them with their greatest challenge. In one of the hospitals, it had ceased to be a challenge and was simply a frustration, causing a high turnover among the more competent managers.

A curious but not uncommon way to handle the complex question of structure is to leave it as vague as possible. The most charitable description of this tactic is "unwise." A new division of labor is always unsettling, and it is important to help participants resettle into desirable patterns. Leaving structure vague allows them to select their own adjustments under conditions which are bound to produce a degree of insecurity. It is poor management to avoid an error by avoiding decisions. Structure will develop, and it is appropriate for those with a clear conception of organizational purpose to shape the structure in ways which will achieve that purpose.

To summarize, the first task in planning for a unit management program is to be clear on the objectives it is intended to accomplish. This establishes a basic premise for three other decisions:

1. the activities to be assigned to SUM;
2. the desired orientation of the unit management program;
3. the organization structure for unit management.

These we have discussed. In turn, decisions in these areas become

premises for three lesser, but still important, decisions concerning the extent of the unit management program, the qualifications of personnel, and the training investments required for success. These three areas will be taken up in turn below.

EXTENT OF UNIT MANAGEMENT

The extent of unit management has three dimensions:

1. how many tasks and responsibilities are given to SUM;
2. how many parts of the hospital SUM covers;
3. how many hours of the week it provides this coverage.

The first is obviously the most important, and has already been given detailed attention. It is the second and third which will be considered here.

1. Unit Coverage

There seems little merit in having designed coverage stop short of all patient units. (In one of the study hospitals there was some question as to whether units with a large number of private duty nurses required unit management, but in no other study hospitals was there doubt that the goal was complete coverage of all patient units.) Nurses do transfer or float from unit to unit, and to have two different systems of unit operation in the same hospital means that they as well as housekeeping, dietary, maintenance, engineering, laboratory, and other non-patient departments must adapt to two systems. This should be avoided if possible.

The more central question of coverage concerns the extension of unit management to the out-patient department and other non-patient departments. In both cases, out-patient department and ancillary services, different contributions will be made by unit management from that in patient care units.

One of the curious aspects of hospital organization is the degree to which management itself has not been recognized as an important element in the successful delivery of health services. The president of Presbyterian St. Luke's, one of the study hospitals, was quite explicit in stating his conviction that the practice of and training in management should be recognized as a hospital function fully as much as the practice of and training in medicine, surgery, and other professions required for health care.

With this conception, unit management can go far beyond a "serve nursing" orientation. It is, after all, not unit management; it is management; the process of bringing rational economic and organizational decisions into an environment where professionals

practice. The same logic which says the nurse should be given an environment in which she can nurse applies to the professionals which now run ancillary departments.

The extension of the unit management program to departments other than patient units has not gone very far. In only one of the study hospitals had this been introduced, and even here it was through the introduction of administrative assistants, which in the patient unit areas were at two levels above the unit managers. Also, these administrative assistants reported both to an administrative head and the department chief, in a context which suggested that they saw themselves and were seen by other than their administrative head as "belonging" to the department. The extension of a management orientation beyond the patient unit may not be feasible until SUM has been more generally accepted in the hospital community.

2. Time Coverage

The single most important issue in the question of coverage is whether the unit management department is truly responsible for assigned activities, or whether it is responsible for them only from 8:00 to 5:00, five days a week. Particularly in hospitals where nurses rotate, there can be no honest transfer of responsibility when everything falls back on the nurse for 16 of the 24 hours each day and all weekend. This problem was not always recognized in early installations, and created considerable difficulty. In effect, the better the SUM program, the more the frustration felt by nurses required to accept responsibility when SUM personnel went home for the day.

It is quite true that the coordinative and supervisory activities of unit managers are at a peak during the day shift. In other shifts, activities decline, but responsibility does not. A number of hospitals have, therefore, emphasized providing seven day a week coverage as soon as possible, and 16 hour a day coverage soon after. In two of the study hospitals, some form of 24 hour coverage was provided seven days a week.

Perhaps the first things to recognize in moving from 40 hour a week coverage to 168 hour a week coverage is substantial increase in personnel requirements, and the need to face complex scheduling problems. Typical coverage on evenings is at half or less the level of days, and on nights in the study hospitals providing coverage it is minimal—one manager for the entire hospital.

The problems associated with a large staff and multiple shift coverage can be reduced by staying with a smaller unit manage-

ment program. The number of activities transferred to SUM, particularly the labor-using activities such as housekeeping, dietary, or transportation creates the need for a large staff. Nevertheless, a unit management program which does scarcely more than a good ward clerk would do is unlikely to do more for the hospital than hiring good ward clerks. To genuinely restructure the responsibilities for patient care, these problems must be faced.

3. Introducing the Program

It is desirable to move totally from one system to another in order to avoid the presence of both old and new systems within the same hospital. If resources are available to recruit, select, and train unit personnel, and prepare all parts of the hospital for the change, this course is the wisest. Few hospitals have such resources, and the actual alternatives are thus to prepare many poorly, or a few well. Obviously, the latter is a better strategy, and also gives the opportunity to set up an experimental unit or units, and thus blend the preparation stage with the implementation stage. The total, across-the-board introduction is to be preferred only if resources can be freed to do it well.

UNIT MANAGER QUALIFICATIONS

One thing concerning unit manager qualifications needs considerable emphasis. Setting these qualifications is not an independent decision; the decisions made concerning activities to be transferred, orientation of the program, and the organization structure for SUM prescribe a role for the unit manager and persons hired must have qualifications appropriate to that role.

One hospital with a "serve nursing" orientation in mind showed commendable realism in its selection criteria. One of the considerations given particular emphasis was that, " . . . as a non-professional in the status-conscious world of the hospital, it would be necessary for the floor manager to accept graciously her relative lack of prestige among the hospital personnel with higher levels of education and more extensive training." The hospital looked for mature women, ideally between the ages of 35 and 50 and with a high school education, and placed the salary at a point between that of a stenographer and a general duty nurse.

1. Education Requirements

A majority of the study hospitals was less clear on the tight relation between unit manager qualifications and the role which the unit manager was expected to play. It is fair to say that two of the

study hospitals over-hired in the sense of getting people who could not be sufficiently challenged by their work. In one of them, it led to a rapid turnover among the college-trained unit managers. At the time of the study, two managers who had been there for less than two years were preparing to leave, and were quite explicit that they were unwilling to play the "handmaiden to the nurse" role which was being forced on them.

The relation of activities assigned to SUM and required unit manager qualifications are quite clear, and perfectly congruent with the qualifications required by the orientation of the program. A program which includes responsibility for ward clerical, housekeeping, dietary, and transportation activities requires higher competence and more mature and experienced personnel than a program which excludes part of these activities. Nevertheless, a college degree is not required, though it will not be a disadvantage as it is in the "handmaiden to nursing" role. If the SUM program has both an administrative orientation and extensive supervisory responsibilities, then administrative competence in a manager is required. The opportunity to contribute to hospital efficiency is great, and it is desirable to have a person in the role of unit manager likely to seek out these opportunities.

In Massachusetts General Hospital, the unit manager position is becoming a training position for hospital administration; as one of the unit managers pointed out, there is a tremendous advantage in starting out right at the heart of the hospital organization, the patient unit. Another study hospital has also accepted an administrative orientation, but has structured the SUM organization to make a position one level above the unit manager the key decision-making and opportunity-seeking slot. This has been less successful. Two examples can be only suggestive, but it appears that if a hospital has selected the goals of professionalizing nursing and bringing the management of the patient units under hospital administration, it is wise to build the unit manager position into a significant job, rather than building the significant job at the next higher level. The trade-off cost is accepting a three-to-five year stay as the probable maximum for a unit manager, and lessening substantially the potential for moving up into that position from below. Both are significant disadvantages.

2. Other Relevant Attributes

A number of the study hospitals and others with which the study team had contact indicate that prior hospital experience is not an advantage. There is apparently a problem of "unlearning" attitudes

that offsets the advantage of knowing things that are helpful. A concern with establishing status before one has produced something to justify it is a serious disadvantage, and has complicated the use of college graduates.

One hospital found it was easier to find women than men of required qualifications at the salary it was paying. However, it appears that a male unit manager develops effective work relations with nursing and service departments more easily than female managers, though the actual ratio of female to male managers in the study hospitals was three to one.

The typical 1967 salary for unit managers was in the $450–$550 range. In 1969, explicit data relating the unit manager salary to nursing salaries were collected with results shown in Table II-7.

TABLE II-7
Comparison of Unit Manager and Nursing Salaries in SUM Hospitals, 1969

Median Head Nurse Salary	$750.00
Median R.N. Salary	$655.00
Median Unit Manager Salary	$595.00
Percent of hospitals with unit manager salary:	
At head nurse level or above	16%
Below head nurse and at R.N. level or above	25%
Below R.N. level	59%
	100%

Although the figures provide useful guidelines, they describe programs rather than provide suggestions to hospitals considering the introduction of SUM salary levels. Salary levels for unit managers should be set after required qualifications have been determined, just as the latter should be determined after the more fundamental task transfer, orientation, and structure decisions have been made.

TRAINING

If a hospital has gone into SUM on a basis of "we'll let the unit manager work out his own job," it will have no training problem, but it will have a program failure. Training is critical, and hospitals considering SUM need to recognize that a substantial investment in training time will be required if a unit management program is to be successful. One of the study hospitals hired the first unit

managers a week before they went on the floor to take over responsibilities from nursing. This was not the beginning of a successful introduction.

Good training has an important by-product. If the unit manager is on top of the technical requirements of the job, a focus on being "one jump ahead of the nurse" makes good sense. If he is not, this focus simply creates problems, since it will appear that he is striving for a status he does not deserve.

SO—WHAT KIND OF PROGRAM?

It is clear from the foregoing that unit management is not a single package. Rather, it is an approach that can vary in its implementation with the goals which are set for it. With these goals in mind, three key decisions need to be made concerning actual tasks transferred, the orientation of the program, and the organizational structure which will be established. In turn, these decisions set the framework in which other decisions can be made concerning coverage, unit manager qualifications, salary levels, promotional ladders, and training investments required.

Hospitals have a choice of relieving the head nurse of some of the pressure on her, or of significantly changing their patient unit organization. If a hospital goes the first route, costs should not be high, neither will the benefits be substantial. Moving fully toward a subdivision of tasks on the patient unit requires a substantial investment. This investment is in money, space, and perhaps most important, in top-level administration time. This decision should be made before the start, otherwise it will be just another program that takes on a life of its own, forcing its own imperatives rather than being shaped to fit the goals established for it.

The preferences of the study team should already be clear, but the following statement will make these preferences explicit:

> Face high initial investments, and the knowledge that costs will not be significantly reduced. The relevant purpose to be achieved is not immediate cost reduction, but the development of a structure that will make cost and quality control possible, in part by permitting a thoroughgoing redefinition of the nursing role in a hospital.
>
> This requires a maximum activity and responsibility transfer to the unit, which in turn requires an administrative orientation, a larger than average patient unit (perhaps 50–75 beds for intermediate care units), one manager per unit, preferably male and college educated with perceived status equal to the head nurse.
>
> Provide 24-hour, 7-day coverage in all parts of the hospital, and

make sure that unit personnel at the stewardess or unit aide level have jobs structured that make them patient oriented, which means; combine activities around the patient, not around a skill (floor cleaning, tray serving, bed making, etc.).

Face the unpleasant fact that ancillary department costs will not drop as much as unit management costs will increase; focus on the fact that unit management represents a structure for gaining cost control, and look for ways to move more toward the decentralization of decisions that will give the unit manager meaningful control, and will permit his meaningful involvement in quality control with the physician and nurse.

Unit manager working with ward clerk

CHAPTER III.
MANAGEMENT OF CHANGE*

Getting from one organization to another, such as moving from a traditional patient unit organization to a unit management structure, requires persons to change their ideas and feelings about their jobs and about their relationships with others. Such experiences can be very painful and threatening, thus making change difficult. The intractability of this human element causes some managers to avoid change altogether and tolerate peaceful stagnation and others to arbitrarily enforce change and tolerate the human problems it creates. There is a better way to bring about change; this chapter will provide some ideas needed in introducing SUM.

The impact of SUM on nursing, on ancillary departments, and ultimately, on the total hospital can be considerable. The transition period, from initiation of unit management until relative stability is attained, may require one to five years, or even longer, depending on how the implementation and the change process are managed. There may be problems at every phase of the change process, but they can be managed when anticipated and understood.

1. Why Do Good Ideas Fail?

The types of change which management attempts to implement in organizations range from those which can be effected via a memorandum to those which require a change in the work habits and attitudes of personnel. Technical or equipment changes have their social aspects but do not involve the complexity of social change. They typically cause little disruption of the system. Social change, on the other hand, involves the skills, values, attitudes, and relationships of many people. It is these which constitute the problem for the manager of social change. The problem which will be encountered has three components which deserve consideration: the individual, the group, and the system. All three levels represent sources of possible resistance to the change.

*Robert L. Smith, Ph.D., Assistant Professor of Psychology in Nursing and Research Associate in the Bureau of Hospital Administration, The University of Michigan, had the primary responsibility for drafting this chapter.

The Individual Level

The individual in an organization has acquired a certain set of skills and feelings which let him fit in the organization. There is comfort and security in having acquired an unambiguous relationship with the organization. A proposed social change project threatens this security. A person worries about whether his skills are obsolete, whether he can acquire the new skills, whether he will lose status, and even whether he will lose his job. Some, who cannot stand the ambiguity, will quit. Others will stay frozen in "the old way of doing things" and represent a threat to the success of a new program. Some of this group may become locked in what will be inaccurately perceived to be a "personality" conflict with personnel representing the new program. We observed many such "personality" conflicts generated by feelings of insecurity. Often the tensions generated by such conditions will lead to turnover among both the nurses and unit management personnel.

The Unit Level

Unit management will force a new pattern of relations among the nursing personnel. Under the traditional system the nurses on a unit have developed patterns of interaction which get work done, define status relations, and generally provide a stable and functioning work environment. Change to unit management disrupts these relations. The head nurse and team leaders may take more time to plan and coordinate patient care and perhaps give closer supervision and less autonomy to LPNs than before with the result that the LPN's job satisfaction is lower. The typical observation on units with a new SUM program is that nurses do not seem to know what to do. It is no longer clear to them how they are to spend their time or how to relate with others.

The System Level

The new SUM department will disrupt ancient inter-departmental relationships. The unit manager will typically replace nursing as the primary contact on the patient care unit. The head nurse has for so long been the central person on the unit that ancillary department personnel will continue to wish to speak only to her or "a nurse." They will be unclear about the purpose and competence of the new department. The new department, as it clarifies its purpose, will be making demands on the ancillary departments they may be unable or not wish to meet. These unexpected demands will tend to be resisted. The less prepared the ancillary departments are for SUM, the greater the resistance and the lon-

ger the transition from implementation to integration which can be expected.

An example from one of the study hospitals can serve to illustrate many of these problems. The decision was made to transfer housekeeping maids to unit management to be supervised by unit managers. The executive housekeeper was not involved in the planning and implementation of this change; she learned of the plan when asked to transfer the personnel. She interpreted this as a move to replace her. She briefed her personnel concerning the change in their supervision in such a way that they in turn felt threatened about their own jobs and had difficulty accepting the change. They were more effectively supervised (nurses claim they never saw the units cleaner) but retained their old loyalties to housekeeping. The resistances growing from the way the change had been implemented became so intense that administration retreated, and three years later the planned change had not yet been made.

2. Pre-Implementation Steps

The management of change must succeed at all three levels if costly and damaging resistance is to be avoided. The important point is that these factors must receive attention before the implementation of the program. The pre-implementation groundwork includes three important objectives: initiation, the successful launching and selling the idea; planning the unit management program; and preparation of personnel for the introduction.

Initiation

Selling the idea to key personnel right at the beginning is important. Initially, internal study groups might be established involving the medical and nursing services, the administration, and relevant ancillary department heads, to survey the problem and review the unit management literature. Key personnel who may represent sources of powerful resistance might be sent to workshops on unit management; the high acceptance of the SUM idea among workshop participants can constitute a powerful social influence.

Planning for SUM

Once the idea has wide acceptance in principle from key personnel, formal planning can begin. A key planning principle is this: the more broadly based the representation of those directly affected, the smoother the implementation, the less intense the transition problems, the better the morale, the more unit management will be viewed with approval, and so on. If those whose day-to-day

activities are affected by the change are involved in discussion and decisions about the detailed working of the new system, greater understanding and commitment to the action can be expected. One can also expect that participation in planning will produce a SUM model most appropriate to the problems of the hospital. A doctor in one of the study hospitals said it was too bad more of his colleagues did not have the same opportunity as he to work on the committee concerned with the implementation of SUM so they could fully understand its value.

What has been described is the planning pattern which characterizes most successful change programs in organizations. This is the shared pattern; that is, decision-making is shared. The more typical pattern of initiating social change programs can, in contrast, be designated as the unilateral pattern. The management works out the details and then announces them in a memo, a meeting, or via new job descriptions. Under such circumstances, one would expect greater ambiguity to be experienced by the affected personnel, greater resistance, and much resulting distrust and hostility. Interpersonal influence is far superior in generating acceptance and is also a powerful factor in generating resistance. What this suggests is that even with the unilateral pattern of initiation of change, key personnel from units not immediately to be phased into the program should somehow be familiarized with the reason for the program, the details of the program, and progress of the initial units, so they can play a positive role in the informal communication structure.

There are at least three degrees of personnel involvement possible during the planning stage: the participation in planning by relevant personnel and representatives of relevant agencies; consultation with those personnel tangentially affected to obtain suggestions and feedback concerning the details of the new program; and finally, those who will play no direct role during the planning stage but who should be kept informed of developments. A special *SUM Newsletter* and/or progress reports at meetings may serve to keep personnel informed.

There is not one planning area, but three: the SUM model, nursing, and the new relationship of the ancillary departments to SUM and nursing. In Chapter II some suggestions for the SUM area were made, but care must also be taken to plan the new relations with ancillary departments. A new nursing model is even more important to clarify for nurses their new role on the unit. Nurses in the study hospitals characterized the impact of unit management on their jobs in two interestingly different ways: some saw them-

selves being relieved of certain tasks; others as now having the opportunity to do different things. From such attitudes it is possible to infer how SUM was presented to the nurses and whether or not a new nursing model was developed. It is important that a new nursing model be developed in detail and that the dissemination of information to the units emphasize the new responsibilities rather than the giving up of the old.

Preparation of Personnel

All affected personnel should be kept informed of developments throughout the planning period. After the planning stage the unit manager should be trained and the nurses should receive a thorough orientation concerning the new nature of their job.

The training of the unit manager should take into account two component skills: how to carry out task responsiblities; and the interpersonal relations important to his or her new position on the unit, including relations with the ancillary departments as well as nursing. The head nurse and her staff should be well informed about what will be expected of them once unit management is implemented. Finally, the unit personnel should be involved collectively in the final planning for the implementation of SUM on their unit. There should be opportunity at this time for considerable question-asking in order to prepare all for what to expect of each other. If possible, medical personnel should be included in such activities, for during the early phase of SUM, in most of the study hospitals, the medical staff insisted on continuing to deal only with the head nurse on all non-nursing matters.

THE CHANGE PROCESS: PHASE I—DEVELOPING THE ROLE

Regardless of how well the SUM program is implemented, there will be problems with the new roles, especially for the head nurse and the unit manager. Others will also experience difficulty: supervisors; ward clerks who now have a new boss and old loyalties; and to a lesser extent, staff nurses and practical nurses. The clerks in all study hospitals resisted the change in reporting procedures. One clerk, after a year, still insisted she worked for the head nurse. Others, such as ward helpers, maids, and SUM workers, may be affected depending on the nature of the new program. The role problems of the head nurse and the unit manager following SUM implementation will be discussed in some detail. The others will not be discussed; the problems of the head nurse and unit manager will suggest the nature of the problems experienced by others.

1. The Head Nurse Role

The head nurse job and that of the staff nurse can be viewed as a social role acquired on the job in the hospital. The head nurse's behavior is shaped by inputs from unit personnel, ancillary departments, and by expectations of the hospital administration, and the medical staff. The head nurse role represents a patterned set of values, skills, and attitudes which she experiences as very natural but which she would be hard put to explicate. It is this integrated set of skills, values, and attitudes which is severely disrupted when an organizational change such as unit management is initiated. Naturally, it can become a threatening experience for the head nurse, and is the reason so much resistance is generated. This is also the reason so much resistance can be found throughout the unit, even though there is strong nursing administration support for the program. This is why the head nurse is going to experience considerable "pain" in accepting and committing herself to the new program.

The essence of the problem for the head nurse is to unlearn a set of responses, behavioral and attitudinal, formerly elicited by the events of the day on the unit. The old responses compete with the new responses and the old responses are often hard to suppress. It is always easier to train a new person into a new role than retrain a person under such circumstances. One hospital in the study had former supervisors, former nursing faculty, and former head nurses learn the new head nurse role. They observe that the former supervisors and especially the former faculty members learned the new role much more quickly than did the head nurses. The faculty members had no old responses to suppress and could concentrate on learning the responses appropriate to the new role. Their unit managers developed their own roles more efficiently and effectively also. Such observations are not unusual. Unlearning the old role, suppressing the old automatic "natural" responses to stimuli, interferes with acquiring the new role and also has a negative effect on the unit manager's role acquisition.

One characteristic of the traditional head nurse role is that she is supposed to know everything. This feeling will persist after unit management begins and she will feel uncomfortable not knowing things.

What Can Be Done?

Since the problem of learning a new role will occur, it is best to prepare for it. There are at least three measures which can be taken to prepare the head nurse and other nursing personnel

affected by the change: acquaint the nurse with the problems of role change; provide institutional, social, and emotional support; and provide nursing and the head nurse with a clear new nursing model.

The head nurse should be told just what she will be going through. She should understand about the problems of unlearning, of having to suppress the old acts and feelings. She should understand that failure to do so makes things more difficult for the new unit manager. This suggestion is based on the premise that she can then better recognize what she is experiencing and can more self-consciously deal with the problems.

At the same time, the head nurse should receive considerable social and institutional support as she learns her new role and drops old behaviors and attitudes. She should have the opportunity to express freely her feelings and ideas and it is important that her successes be recognized at each stage as she adapts. These experiences and opportunities are in addition to institutionalized problem-solving opportunities set up with the unit manager. One of the study hospitals had a good way of handling this need. For reasons having nothing to do with unit management, the hospital had a nurse with the title, administrative assistant, who served in a sort of ombudsman role. Nursing personnel and others came to her at any time they felt they needed to get something off their chests. This nurse did not always wait for people to come to her but would go to people who seemed to need some emotional support.

The third measure that can be taken is perhaps the most important. It is one thing to shed certain values and attitudes and suppress certain skill behaviors and quite another to acquire a new set. It is important that a viable new role be conceived involving a new set of traditions with implied values, skills, and attitudes. Then the head nurse has a model, has something to move toward rather than only something to move away from. The transition is more difficult if she is only unlearning, only suppressing the old responses. She is only learning what not to do, not what to do. This makes her "new" role a left-over and it may not be a viable whole. So nursing in general and the head nurse role in particular should be reconceptualized. This role reconceptualization should be tailored to meet the needs of the particular hospital.

Regardless of what is done, in time and with personnel turnover, unit management will come to be accepted and seen as "natural," if for no other reason than that nursing no longer has the skills to perform many of the unit management tasks. As new nurses come

into the hospital they are socialized and integrated into the ongoing system. They will experience fewer problems than those who were present at the beginning. However, in the process of being socialized, the nurses will acquire the prevailing attitudes concerning unit management. These can be such that they do not facilitate problem-solving and cooperation. The inter-relations of nursing and SUM in the initial stages provide a heritage which will be lived with years later.

Some Study Findings

The nurses in the SUM study hospitals generally accepted the unit management idea even though in some cases there was considerable tension between the two services. The nurses from the hospital which was experiencing the greatest difficulty were still significantly more approving than indifferent to unit mangement.[1] This finding suggests that the unit mangement idea generally has intrinsic appeal to nurses once they have been exposed to it regardless of the difficulty with any specific program.

2. The Unit Manager Role

The initial unit manager will have to create his role and no matter how thorough the initial job description, the development of the role will be difficult and painful for the manager. He (or she) often does not know the hospital, hospital terminology, forms and procedures, the ward clerk who has become his responsibility, the ward clerk job, the head nurse with whom he is to work, or the key personnel of ancillary departments. The ward clerk will typically have old loyalties to the head nurse and nursing and will be resistant to being supervised by the unit manager especially when the manager does not seem to know the ward clerk job. The nursing supervisor, a possible source of social support, may be having role-definition problems of her own which would limit the support she could provide.

What Can Be Done?

The creation of an entirely new role in a system involving the interpersonal and interdepartmental interactions of the unit manager role is a complex and difficult process. However, some of the

[1]The nurses felt it was possible to do their job better with unit management, that their job was easier and more interesting, and they preferred unit management over the traditional system.

painful aspects can be minimized and the role development facilitated. In the first place, the unit manager should be as well trained as possible, considering the hospital's lack of experience with the new role. In every study hospital, the head nurses and unit managers who had experienced the beginning of SUM reported that a major problem had been the manager's lack of competence. The attitudes developed at this time made the manager's effort to earn the confidence and respect of nursing and his own staff doubly difficult. One hospital which was having difficulty with its SUM program after five years almost gave it up when the program director and most of the managers quit. The administration put one of its new managers in charge as director. Her diagnosis, based on her brief experience as a unit manager, was that the major problem was lack of adequate training for managers. She proceeded carefully to select her managers and trained them thoroughly. She resisted the pressure to expand SUM to all nursing units in the hospital and extended it to additional units only when she had trained managers. At the time of the study, her program was one of the most successful observed.

The manager should have the opportunity to get to know the head nurse with whom he will be working quite well, socially, if possible. He should be well acquainted with the personnel and functions of all ancillary departments, which should have been well briefed concerning unit management. It would be very helpful, as part of the manager's training, to include a few days internship or cross-training in the key ancillary departments.

Both the new manager and the head nurse should be familiar with the nature of the problems of role development each will face so they can anticipate and recognize instances of the problem and be more helpful to each other. Finally, the manager should have regular access to higher levels of authority for aid in dealing with the substantive and emotional aspects of role development. He is often going to feel quite lonely as a newcomer and outsider on the patient care unit and will need understanding institutional support.

One recurring theme picked up from nurses in the study hospitals was that they were very unprepared for what they initially experienced with SUM. They were presented with an ideal type which was far removed from reality. The discrepancy caused much ill feeling. This suggests a more realistic preparation for the nurses which would include not only the ideal but the real problems to be encountered and solved before attaining the ideal.

THE CHANGE PROCESS: PHASE II—UNIT INTEGRATION

The initial role problems become less intense when the unit manager, the head nurse, and other unit personnel have a clear understanding of their own and the other's role. Then a different and organizationally more serious set of problems typically becomes apparent. Two simple realities cause those problems. First, what had once been an integrated set of tasks and responsibilities handled by a single person, the head nurse, is now two separate sets lacking integration. Second, there are two new models of task and responsibility definitions: the SUM model and the nursing model. Role definitions made separately by the unit manager and the head nurse result in gaps and overlaps concerning who does what.

The physical proximity of the two services and their high interdependence makes the situation ripe for conflict and usually that is what occurs. The symptoms of conflict are easy to observe: expression of feelings of distrust and suspicion; decision-making based on distortion of information; and interaction characterized by rigidity, formality, and avoidance to the extent possible.

Given the development of such conditions, several kinds of interaction between the two services can be observed. For example, one typical pattern is to make unreasonable demands. Usually, it is nursing which makes some demand of unit management. Unit management then will make a counter demand such as "fill out the form," or "have the request in by a certain hour." Exaggeration becomes the order of the day. There is often deliberate distortion so that urgency and needs are misrepresented. Power plays become common with each service going higher in the structure to get pressure applied on the other group rather than relying on direct problem-solving. There is complete mistrust. In time, all communications are assumed to be exaggerated, requests padded, and urgency nonexistent. Then, there is rigid resistance. The point is reached where neither service can cooperate even if it would like to. One side cannot afford to cooperate unilaterally because it would subordinate that service to the other. So, the organizational experience resulting from the cooperative act would be a kind of punishment, not reward. Neither side can afford to concede a point to the other. Contacts between services become strictly limited in order to avoid discomfort and to provide protection from real but minimized shortcomings and real but again minimized flexibility.

What are the consequences? They are often quite severe. The

services will attempt to circumvent each other when they can. In one study hospital, for instance, nursing would call maintenance directly rather than work through the unit manager. Direct unilateral action will be taken which usurps the jurisdiction of the other service. Blaming and blame-avoidance becomes commonplace. Vindictiveness, "make him squirm," becomes a common impulse. In one hospital, nursing administration asked all supervisors and head nurses to call directly to the service unit department head with every single complaint, day or night. The department head received so many phone calls at home he changed to an unlisted number. Problem-solving attempts will frequently degenerate into greater formalization of rules about who makes decisions and who has jurisdiction. Such decisions solve nothing and are less functional in the long run. They tend to be experienced as defeats by one or both parties and generate more bad feelings for maintaining or increasing the conflict.

Almost every study hospital experienced a period of such conditions, although the intensity of the conflict varied. Where the conflict was at an intense level, high turnover among unit managers became a problem. In two instances, the turnover was so high that the survival of the program was in question after the departure of the program director. The important point here is that every hospital experiences some degree of conflict. It is unavoidable because of the high interdependence and physical proximity of the two services. The problem is to so manage the change process that the conflict does not get out of hand and destroy the program or that the conditions become so chronic that further progress is impeded.

1. What Can Be Done?

We have said that the interdependence and proximity of the two services are a source of inevitable conflict. But we need to say more. What is there about the relationship between the two services that can generate conflict? There are several factors. Among them are: the relative status of the unit manager and head nurse; overload of the unit manager and head nurse; organizational competence of the two services; and the different nature of the tasks and responsibilities. Each of these factors will be discussed separately along with suggestions about how to avoid the development of a chronic conflict state.

Relative Status

Equivalent status on the unit between the two services will lead to certain problems but will eliminate others. Some of the pros and

cons of the alternatives were discussed in Chapter II.

The subordinate group is usually unit management if the hospital decides on other than equivalent status. The result usually is pressure on the new service to adapt to nursing, the dominant group. A major effect is resentment on the part of the subordinate personnel. Most organizations can point to internal examples of such interdepartmental relations. The subordinated group, SUM, will usually try to define tasks and responsibilities to be relatively independent of the dominant group. This is a natural response and can result in a powerful source of conflict.

Hospitals that systematically develop the "serve nursing" orientation among their unit management personnel usually have many formal and informal methods of signifying nursing's dominant status. In one study hospital which had successfully implemented a subordinate type SUM (successful in that the system was relatively stable, conflict was contained, manager job turnover low, and job satisfaction reasonably high), the unit managers, who were responsible for maintaining all standard supplies, had to obtain the head nurse's signature on all requisitions to central supplies and to laundry for linen. The managers were frequently reminded they were there to serve nursing. The SUM workers likewise were frequently so reminded by both nursing personnel (especially the nurse's aide) and the unit manager. The women in the manager role were upset about these little indignities and resentful over the disparity between their pay relative to the head and staff nurses and the fact that they were each supervising 15 to 20 people.[2]

Overload

Overload has a mixed potential for conflict or collaboration. If the implementation process has been collaborative and such a mood established, then under conditions of overload, the unit manager and head nurse may turn to each other for help. However, conflict is more likely because the increased tension and frustration accompanying overload often lead to aggression. Overload

[2]The discussion in Chapter II emphasized the relationship between the selection of purpose and the characteristics sought in the unit manager. Hospitals in large urban areas which decide on the subordinated role for unit management where the pay is modest and the typical unit manager is a mature woman can expect in time to have mostly black unit managers (with black clerks and SUM workers). If the RNs are white, the conflict potential of this situation can be explosive with the interdepartmental conflict gradually taking on racial overtones which can greatly increase the difficulty of managing the conflict.

may decrease the time available to fully consider the implications of events and limit the time available to make moves to contain conflict. Overload conditions will heighten the intensity of any conflict already present and will contribute to the difficulty of changing an ongoing conflict pattern.

In summary, overload will probably generate or intensify already present conflict. The head nurse and unit manager roles should be assessed with respect to amount of overload and each person should have sufficient time to handle the inter-service substantive and process problems, especially at the beginning of SUM.

Organizational Competence

How strong or how inept the two services are will have a powerful effect on how they get along. If both services are well administered, if service objectives are clear, if the personnel are competent and attain objectives, and if job morale is high, one has the optimal conditions for collaborative interaction. The other extreme, both services floundering, unclear regarding objectives, and with low morale, is optimal for scapegoating. A nursing service which was strong and vital could probably live with a chaotic unit management program. It would not be a satisfactory condition for nursing but nursing would be unlikely to be bitterly complaining and blaming. Rather, one would expect facilitative problem solving attempts from nursing in order to improve unit management.

The other alternative is a strong unit management program and an ineffective nursing service. Such a state is unlikely. It would be difficult to develop a very effective unit managment service because of considerable wasted effort in dealing with interservice problems especially if the conflict became extremely intense. In summary, then, the stronger the nursing service the less conflict and the best prognosis for unit managment.

Nature of Job

Another source of potential conflict lies in the different nature of the unit managment tasks and nursing tasks. Since the managers are likely to be efficiency oriented, conflict is probable. A value difference in background and job experience can lead to conflict which seems difficult to resolve. The unit managers will value stability; their responsibilities can be organized into a relatively stable set of tasks which can be performed at specified times by specified personnel. Nursing will often be perceived to be interfering with unit management and this "interference" will be resisted. Unit management will feel that nursing does not understand its problems, that if it did, it would conform to the routine times and ways

of getting everything done. Unit managers sometimes feel that if it were not for nurses, they could get their job done better.

Nursing, on the other hand, often requires considerable flexibility. More routine activities can be dropped for emergencies. When SUM does not appear to be as responsive as nursing feels is appropriate, it is devalued. Nursing feels SUM does not understand, cannot be depended on, does not understand that a professional requires flexibility in the system.

Given two such contrasting value orientations, stability vs. flexibility, considerable conflict and tension are possible. This potential source of conflict is one of the reasons all evaluations of unit performance under unit management should emphasize the overall performance. Emphasis on the separate performances will more likely generate conflict and, if present, intensify it.

2. When Conflict Is Out of Control

If the conflict reaches the point that reality no longer affects decisions and behaviors, it will be important to move the protagonists from their polarized emotional states to a degree of consensus on some issues. One measure which can be taken is to bring in a neutral third party to serve as an observer-information gatherer. One of the study hospitals did just this. It hired a nurse who had some research experience and had the social skills to be accepted by all unit personnel. She was committed to the overall program and succeeded in not becoming identified with the conflict. She spent most of her time on the unit observing behavior and followed up all major incidents. She had the detachment to perceive what the problems were independent of the personalities involved. She was able to identify the system problems which were generating the conflict. With this perspective, it was possible to begin to examine relationships without recriminations and counter charges.

Good management of the change process requires not only sophisticated implementation but accurate information about how things are going for SUM and nursing—therefore, one may wish to establish at the beginning the neutral observer role as part of the information gathering and problem-solving machinery.

As a remedial measure and as a general principle, any time either service performs a cooperative act, it should not go unnoticed. It should receive public recognition, public reinforcement. The objective of this measure in managing conflict will be to move the chief protagonists from polarized positions into a problem-solving mood.

If, as sometime will be the case, the "personality conflict" is out of hand, one may have to accept the loss of some unit managers (or less likely, head nurses) in order to obtain a fresh start. A head nurse with a replacement unit manager will probably be highly motivated to achieve some success with the unit management program. After all, the head nurse who finds a series of unit managers to have "bad personalities" is in an awkward position.

3. Some Study Findings

Acceptance of SUM

The study showed that nurses with low-rated tension with SUM, had high consensus concerning who had responsibility for what activity. The good head nurse-unit manager agreement concerning task responsibility pointed to high acceptance of unit management.

Within SUM, the characteristics which best indicated high acceptance among nurses were the presence of the "serve administration" theme, higher education of managers, and a larger number of activities transferred to the new service.

Status of Unit Manager

Another set of findings concerned the power (relative to the head nurse's power) attributed to the unit manager by nursing. This was of interest because of the concern, when designing a unit managment program, with the relative head nurse-unit manager status. Usually the concern is to be sure not to threaten the head nurse, rather to subordinate the unit management service. However, more equal status may be preferable.

For nursing, the study showed that the more advanced the change phase, the better the department head agreement concerning unit task responsibility, and the smaller the unit, the greater power (relative to the head nurse) attributed to the manager by nurses.

For unit management, the findings are similar: advanced change phase, fewer beds, and male managers predicted to higher power. These findings were interpreted to mean that being perceived by nursing to be powerful means being perceived as competent and effective (i.e., more advanced change phase). Good department head agreement suggests that there is more open communication at levels above the unit and stronger institutional support for the program. The fewer beds under the manager and head nurse suggest that structurally they have the opportunity to work better on the inter-service problems and that the unit manager's performance is more visible and probably more responsive to nursing

needs. The fewer beds under the head nurse probably are associated with a smaller staff and suggest less probability of overload and therefore more readiness and opportunity for problem solving. The male managers probably are viewed as having more power simply because they are males. However, there may be another factor also: being male and dealing with female head nurses, they are probably more influential in initiating successful problem-solving efforts.

Unit Manager-Head Nurse Agreement

The final set of findings to be reviewed is the factors which predict to high agreement between the head nurse and unit manager concerning which service has responsibilitiy for which non-nursing tasks (see the list of tasks used in Appendix 1). The findings are comparable to those already covered such as: more advanced change phase and older SUM programs predicted to agreement. So did task transfer: more to SUM, fewer tasks remaining with nursing and ancillary departments. Better educated and being male also predicted for SUM, as did good SUM-nursing department head agreement on task responsibility. The final factors were a smaller RN staff and a more participative head nurse leadership style.

It can be inferred that, on units representing better head nurse-manager agreement, the head nurse experienced less overload (fewer tasks) and had a more relaxed leadership style (more participative). It would seem also that the managers were more sophisticated about problem-solving (male and better educated). These factors along with the apparent structual support (good department head agreement) all suggest increased opportunity for open communication and higher capability for taking advantage of the opportunity.

PHASE III—SYSTEM INTEGRATION

In time, the SUM-nursing conflict will tend to become stable, if not fully resolved. It is then that another set of problems becomes apparent involving SUM and the ancillary departments. The unit manager finds he cannot always fulfill his responsibilities when he has to depend on some of these other departments. Which department or departments vary with the hospital—in one, it is maintenance, in another, housekeeping, or some other department that becomes the bane of his life. The manager is then caught between nursing, which makes what he comes to accept as legitimate demands, and the often inadequate procedures of the ancillary

departments. The manager begins to feel increasingly frustrated.

The ancillary departments typically are not responsive to SUM's problem solving attempts. They have no incentive to cooperate because they are not experiencing any "pain." They are resistant to setting up separate procedures for the SUM units because they often do not have the resources to devote to mutual problem solving, and they sometimes are unclear concerning the nature of the new department.

It is at this point that the hospital begins to experience an unexpected consequence of unit management. SUM was expected to help solve problems on the patient care unit. What begins to become clear is that there is another set of problems with ancillary departments that interferes with the efficient and effective operation of the unit. Since this was not expected, no attention has been devoted to this area. From the administration's point of view, then, a successful SUM program brings with it many new problems.

Each study hospital could serve as a case study of such ancillary department relations. In one hospital, the managers noted they were devoting an excessive amount of time filling out requisitions and wanted to develop a checklist for standard supply items. They developed a prototype but after a year had *not* succeeded in obtaining Central Stores' cooperation in implementing the change. In another hospital with stewardesses, who brought in the patient's tray, dietary began to get criticism it had never experienced before regarding such items as the wrong tray, missing items, and cold food. In another, pharmacy's refusal to deal with anyone other than a nurse was an issue. In still another, the indifference of housekeeping and maintenance to unit managers' requests kept the managers in a constantly vulnerable position with nursing.

It is at this point, when unit managers cannot deliver, when they perceive the reason, but cannot establish mutual problem solving efforts with the ancillary departments, and especially when the Phase II (unit integration) problems have not been completely resolved, that the lowest point in the history of the hospital's unit management program occurs. Morale is the lowest, turnover is high, and often the SUM department head leaves. The department almost goes out of existence. Hospital and nursing administration at this time are faced with the decision whether to return to the traditional patient care organization or salvage unit management. In all the study hospitals, the latter decision was adopted. Nurses at the unit level had accepted the SUM idea in principle even though it was not functioning well. Nursing administration was committed to getting nursing away from the trend toward increasing numbers

of non-nursing functions. In other words, the original reasons for initiating unit management were still valid. In addition, hospital administration had become increasingly concerned with how the patient care unit functioned and the nature of the problems was clearer.

When the decision is made to salvage the program, the SUM department typically gets a new head, is sometimes moved to a new spot in the hospital organization, one reflecting its new status, and the administration's interest in and commitment to the new department is publicized. From this point on, the unit management program tends to grow and prosper. There are still problems, of course, but with the new image and personnel, the unit management program becomes and remains strong.

Some aspects of this phase are probably inevitable. That is, unit management will not know where the key problem areas are until it has had some experience and, perhaps more important, has achieved some degree of integration and stability with nursing. That is, so long as the unit integration problem is unresolved, it is difficult for the manager to sort out his experiences and attain perspective on the role of the ancillary departments. Nursing, for instance, may be dealing with an ancillary department directly so it is difficult to perceive that that department may represent a separate problem independent of the nursing problem.

We noted in the study hospitals that nursing also reached the position, once the unit integration problem was partially solved, where it could identify a serious problem of its own. Its problem, one that creates some discontent, is that it has no viable concept of the role of the professional nurse. Once its problems with unit management are under control, its lack of a professional model becomes readily apparent. As previously suggested, this is a problem that can also be initially attacked in the pre-implementation period.

What Can Be Done?

Even though it may take time before the managers can begin to identify the problems with the ancillary departments, the ancillary departments should, even before implementation, be thoroughly acquainted with the purpose of unit management and the administration's interest in its success. The key ancillary departments might be placed under a single assistant administrator who is committed to the new program, or problem solving machinery might be established early which would provide the opportunity for dealing with the problems as they arose and were identified.

The problems of this phase can begin to be managed in the pre-implementation phase as discussed at the beginning of this chapter.

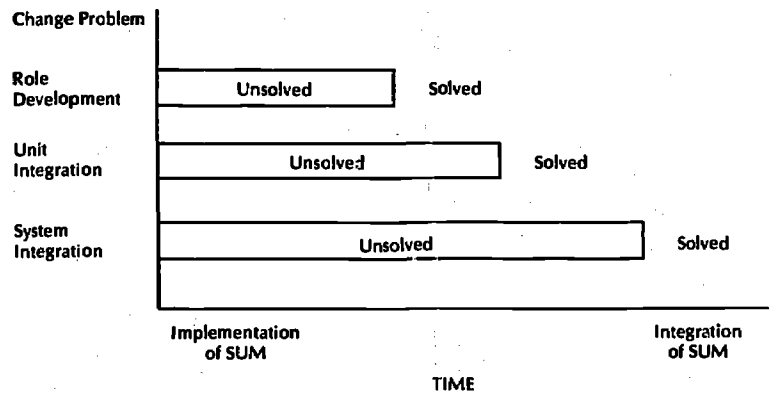
The Phases of Change

Although we have discussed the problems of the phases of social change in an implied chronological order, it should not be inferred that they do not overlap in time. The problems of each phase can be and are all present at once. They have been discussed as they were for a quite practical reason: the chief problem of each phase must be partially solved before the problem of the next phase can be clearly identified and before the personnel have the energy to attack the problem.

Figure III-1 illustrates the overlapping of the three change problems. Directing great attention at the system integration problem, for instance, before the other two sets are solved will be largely wasted effort. Groundwork may be done in advance to facilitate later problem resolution but current effort is best focused on the earlier (with respect to order) unsolved problem. From Figure III-1 one can appreciate the condition which exists if the program development is stopped at the first or second phase. The unsolved problems become chronic sources of discomfort to personnel and prevent moving on to later problems.

FIGURE III-1

Change Problems Over Time



The hospitals in the study tended to be trailblazers with respect to innovations in the management of the patient care unit. They therefore provided rich information concerning the problem of requiring management in the change process. Hospitals which now go into unit management have greater awareness about what to expect and need not experience the problems to the same intensity. Yet as the study hospitals have shown, even the "play by ear" method can lead to success. It merely costs more in time, efficiency, and personnel, and takes longer.

BEYOND PHASE III

One of the consequences of SUM is that hospital administration becomes involved in the administration of the patient care unit. It is too early to be sure what all the long run consequences after SUM will be, but some possibilities have been noted. One thing seems certain—moving toward some version of SUM in larger hospitals is likely an irreversible trend.

1. Added Unit Functions for SUM

Once the new service has been established in the system, the possibility exists for adding relatively easily other functions traditionally the responsibility of ancillary departments or nursing, including some direct patient care activities. Theoretically, any activity of the unit short of those legally restricted to a physician or a registered nurse can become the responsibility of unit management. Once the new structure is established, new functions can be added as they seem feasible and promise increased efficiency.

It is even conceivable, depending on the direction nursing takes, that the unit manager may supervise technicians carrying out medical and nursing orders. Such a radical move has not yet taken place that we know. However, it is being considered.

2. Added Decentralized Functions

Another avenue for extending the functions of unit management is to decentralize some functions currently located elsewhere in the system such as some admissions clerical work or other post discharge paperwork, which can be done more cheaply and efficiently by an effective staff on the unit.

3. Extension of SUM Concept

One trend observed was the extension of the professional management concept to other departments of the hospital. The reasoning was as follows: if the argument for introducing profes-

sional management to free the nurse to nurse is valid, then the argument has equal force with respect to pharmacy, laboratories, out-patient, and other departments. The instances of such extensions of the concept so observed appeared to have been quite effective. Such changes appear to have been easier to institutionalize because only one shift was involved.

4. Need for the RN

In the absence of a new viable nursing model and enhanced professional performance of the RN under SUM, an issue that may arise is whether the RN, as we know her, is any longer needed. There appears to be the feeling in the nursing service that she has a role to play but it is not clear exactly what it is. The problem is that much of what the RN at one time did has been delegated to the LPN and nurses' aide. With unit management assuming responsibility for the clerical and coordinating functions, it is not clear what is left of the RN's old duties other than supervision or taking over some of the LPN level activities. Hospitals with RN shortages are using upgraded LPNs frequently to replace the RN. The general idea is that it may be possible to reconceptualize all present nursing activities into sets which can be carried out by specially trained technicians. One hospital in our study, for example, has tried this with medication technicians passing all medications and handling medication records. This appears to have worked out quite well. Possibly the new role for registered nurses will be one of more clinical responsibility.[3]

5. Clinical Specialists

In line with more responsibility is the idea that a successful unit management program provides the opportunity to institutionalize the extensive utilization of clinical specialists in two general directions. One is that the clinical specialist will consult with the physician, examine the patient, develop a care plan, write nursing orders, and follow the patient. Under this model, RNs or specially trained technicians would carry out the orders under someone else's supervision.[4]

---

[3]Under Dean Dorothy Smith, at the University of Florida, some interesting work is being done on the role of the baccalaureate graduate in developing nursing care plans and in supervising other nursing personnel to carry out these plans.

[4]Significant work in developing the role of clinical specialist is being done at Case Western Reserve College of Nursing in cooperation with Cleveland University Hospitals.

The more usual model is to view the specialist instead as a consultant to the RNs who, it is assumed, will become more sophisticated about the nursing care plans.

6. Decentralized Policy Making

When hospital administration is directly represented at the unit level, there exists the opportunity of establishing decentralized policymaking along with nursing and medicine, the other two services concerned with the operation of the unit. The policy-making may be set at the unit floor or specialty level. Hospitals which are trying this are generally very pleased with the results.

SUMMARY

This study was undertaken to evaluate whether Service Unit Management is serving the purposes claimed, namely, reducing costs, improving quality of care, saving professional nursing time, increasing personnel satisfaction, and setting a stage for further improvements. We found that in general SUM was serving the purposes claimed. Briefly, our findings included the following:

COST

There was no evidence that SUM reduces nor significantly increases personnel costs. SUM has the potential to reduce costs related to ancillary departments, utilization of supplies and equipment, and administration. We inferred that personnel turnover costs were less on SUM units because of the greater job satisfaction of the professional and non-professional personnel.

PERMITS THE NURSE TO RETURN TO THE PATIENT

SUM was effective in relieving nursing of responsibility for many non-nursing activities. The head nurse role, in this respect, is affected more than that of the staff nurse. The impact on the LPN role is minimal.

However, it is clear that the professional nurse has not taken full advantage of the opportunity SUM provides. There is nothing implicit in the SUM concept which suggests different patient care behavior for nurses. To improve nursing care, it is necessary to have a separate parallel program aimed at effective re-orientation of the professional nurse.

QUALITY OF CARE

The evidence showed there is higher quality of patient care on the SUM units both with respect to nursing and to non-nursing care.

The differences were greater for non-nursing care (largely reflecting the effectiveness of SUM) than for nursing care. This also suggests that nursing has not fully exploited the opportunities that SUM provides.

EFFICIENCY

It appears that SUM units do function more efficiently presumably due to a clearer specification of responsibilities and to task specialization. That is, considering quality of care and staffing together, the differences in quality (favoring the SUM units) were greater than can be accounted for by any differences in staffing. Therefore, we infer more effective utilization of unit personnel on SUM units.

MORALE AND TURNOVER OF THE PROFESSIONAL NURSE

We have no information on turnover, but because of the relationship between turnover and job satisfaction (established in other studies), we infer less turnover in SUM hospitals. We found the job satisfaction of nurses to be greater on SUM units. Nurses on SUM units have more positive work experiences and fewer negative experiences.

The job satisfaction of the non-professional personnel was also much higher on SUM units.

SUM SETS STAGE FOR FURTHER INNOVATIONS

A SUM program, once successfully established, provides the opportunity for additional important changes such as radical reconceptualization of nursing, changes in the ancillary departments, decentralization of clerical, administrative, policy-making, and other activities.

In addition to evaluating whether SUM is serving the purposes claimed, we wished to determine the characteristics of unit management programs. We discovered that no two hospitals with SUM had quite the same program. Each hospital had evolved its own version based on its perception of the major purposes to be served and certain political realities in that hospital. Each hospital had to make a set of decisions, many interrelated, to evolve their SUM program. The key issues requiring resolution include:

TASKS AND RESPONSIBILITIES

What jobs can be transferred to unit management? We identified eight sets of activities, any one or all or any combination of which might characterize a unit management program.

Logistic and Clerical

1. Handling supplies, equipment, and contracts with maintenance
2. Traditional ward clerk activities
3. Transcription of physician orders

Patient Support

4. Patient transportation and messenger service
5. Housekeeping
6. Dietary
7. Non-professional direct patient care

Administrative

8. Admitting, accounting, and other activities that can be done more efficiently on the unit.

FOCUS OF SUM

Each unit management program can be characterized by the major purpose to which it is oriented. These orientations are:

1. To serve nursing
2. To serve administration
3. To serve the patient

ORGANIZATIONAL STRUCTURE

The third major choice to be made (after task allocation and the focus of SUM) concerns decisions in regard to the structure of the new department and its relationship to nursing.

1. *The unit manager-head nurse relationship.* This is the "What is a unit?" question. Will there be a manager for each unit or will a manager have two or more units? If the latter, is the manager parallel to the nursing supervisor in nursing or in limbo with no clear working relationship with either the supervisor or head nurse?
2. *Formal Structure.* Is the SUM program to be under nursing or a separate parallel department?

UNIT MANAGER QUALIFICATIONS

The previous decisions, activities transferred and personnel to be supervised, orientation of the program, and organizational structure for SUM define the role of the unit manager and have implications concerning his qualifications. The two principal qualification factors are:

1. *Education.* The main choices here are college degree, some college, or high school diploma.
2. *Experience.* Hospital, business, and/or supervisory experience are the major concerns.

The final set of observations resulting from the SUM study concerns the problem of managing social change. How the SUM program is implemented will often have more to do with its early success or failure than factors intrinsic to the program itself. We identified steps that might be taken to facilitate the implementation of the program and problems to anticipate during the change process.

1. *Initiation.* Key personnel in nursing, administration, medicine, and ancillary departments should understand the nature of SUM and accept the idea in principle.
2. *Planning for SUM.* Planning should involve three levels of participation: those actively involved in the planning; those consulted; and those who are kept informed. The content of the planning should include a reconceptionalization of the nurse's role as well as the development of the manager's role.
3. *Preparation of unit personnel.* The manager should be well trained and the head nurse thoroughly oriented concerning her new role. Unit personnel should be involved in planning the details for implementation of SUM.

THE CHANGE PROCESS

We have identified three major types of problems which require management as the SUM program evolves to become part of the hospital organization.

1. *Developing the role.* Measures must be taken to facilitate the acquiring of new roles by the "old" head nurse and the new unit manager.
2. *Unit integration.* Once the role learning is progressing well, much effort and attention must be directed at integrating the two services, SUM and nursing, so that they work well together toward common objectives. The interdependence and proximity of the two services will generate such conflicts

as the relative status of the manager and head nurse; overload of either or both; the competence of the two services; and the different nature of their tasks and responsibilities.

3. *System integration.* The final set of problems will involve the unit management department with ancillary departments. Administrative attention to practices of the ancillary departments which interfere with the efficient and effective operation of the unit will be necessary to integrate SUM fully into the hospital structure.

Successful SUM programs are raising issues and providing opportunities never visualized by the innovating hospitals which in the late fifties and early sixties began experimenting with SUM. For these reasons, as well as the original purposes claimed for SUM, we expect some form of unit management to be found in most larger hospitals by the end of the seventies. The spread of the innovation will be rapid if the trend we have noted continues: three hospitals in the U.S. had SUM in January 1960; the number was up to 20, five years later; and we estimate there are about 170 as of January 1970. It is our opinion that SUM is here to stay.

APPENDIX

ACTIVITIES LIST
For SUM Units

A. General Activities
1. Answering phone calls to the nursing unit
2. Directing visitors who arrive on the nursing unit
3. Maintaining the census record
4. Admitting patients
5. Discharging patients
6. Transferring patients
7. Block charting medications
8. Block charting treatments
9. Graphic charting of treatments
10. Completing referral records
11. Sending lab specimens
12. Filling out requisitions
13. Sending out requisitions
14. Receiving requisitions
15. Filing requisitions
16. Maintaining diet records
17. Scheduling patients and appointments
18. Caring for patient charts
19. Transcribing physician's orders
20. Tabulating routine narcotics
21. Preparing nursing time schedules
22. Receiving supplies
23. Checking supplies
24. Storing supplies
25. Filling out supply requisitions
26. Sending supply requisitions
27. Receiving supply requisitions
28. Checking supply requisitions
29. Filing supply requisitions
30. Distributing mail to patients
31. Fowarding mail to patients who have left the unit
32. Cleaning discharged patient's rooms
33. Checking discharged patient's rooms
34. Cleaning occupied patient's rooms
35. Checking occupied patient's rooms
36. Clean treatment rooms
37. Checking treatment rooms
38. Cleaning utility rooms
39. Checking utility rooms
40. Cleaning the nursing station
41. Checking the nursing station
42. Cleaning the doctor's conference room.
43. Checking the doctor's conference room
44. Cleaning the corridors
45. Checking the corridors
46. Cleaning the storage rooms
47. Checking the storage rooms
48. Cleaning the equipment rooms
49. Checking the equipment rooms
50. Cleaning equipment assigned temporarily to the unit.
51. Requesting equipment temporarily assigned to the unit
52. Checking equipment temporarily assigned to the unit
53. Cleaning equipment assigned permanently to the unit
54. Checking equipment assigned permanently to the unit
55. Requesting equipment assigned permanently to the unit
56. Collecting dirty linen
57. Transporting linen
58. Storing clean linen
59. Checking linen levels
60. Determining CSS supply levels
61. Changing patient bed curtains
62. Preparing service unit management time schedule

B. Dietary
1. Assembling trays
2. Serving meals to patients
3. Procuring nourishments
4. Maintaining nourishment area
5. Giving menu assistance to patients who require it

C. Transporting Patients to:
1. Conferences
2. Operating room
3. Occupational therapy
4. Physical therapy
5. X-ray
6. Other appointments
7. The nursing unit on admission

Transporting Patients from:
8. Conferences
9. Operating room
10. Occupational therapy

11. Physical therapy
12. X-ray
13. Other appointments
14. The nursing unit on discharge

D. Supplies
1. Procuring linens
2. Distributing linen to nursing area supply points
3. Procuring CSS supplies
4. Distributing CSS supplies to area supply points
5. Procuring administrative supplies (forms, paper clips, pencils, etc.)
6. Procuring patient equipment (suction machines, foot boards, hypothermia units, air pressure mattresses, etc.)

E. Messenger Service
1. Laboratories
2. Record room
3. Clinic
4. Pharmacy
5. Information desk
6. Blood bank
7. Other

F. Supervisory Responsibilities:
has responsibility for the supervision of:
1. Clerks
2. Housekeeping personnel in the nursing unit.
3. Transporters
4. Nursing (RNs)
5. Nursing (non-professional)
6. Dietary assistants
7. Pharmacy aides
8. Admitting department personnel

G. Indirect Patient Care
(Clerical has complete responsibility for completing the following communications
1. Wills
2. Insurance forms
3. Expiration records
4. Incident reports
5. Answers patient call lights

H. Indirect Patient Care
(Water Pitchers)
6. Collecting water pitchers
7. Cleaning water pitchers
8. Filling water pitchers
9. Distribution of water pitchers

ADDITIONAL READINGS

The interested reader can obtain some insights about the problems of introducing change and some ideas about handling the problems from the studies of change programs in industry. For example, Alvin Zander, in his paper *Resistance to Change—Its Analysis and Prevention,*[5] discusses the nature of resistance and suggests some means of decreasing it; Dorwin Cartwright in *Achieving Change in People*[6] focuses on using the group as the medium of change; Alex Bavelas and George Strauss, in their paper, *Group Dynamics and Inter-group Relations,*[7] describe the unexpected and unfortunate consequences of inducing successful change in a sub-unit in a factory while ignoring the implications of the change for the other units in the system; and Larry E. Greiner in *Patterns of Organizational Change*[8] compares successful change programs with those that failed and derives some change principles common to the successful programs. The annotated bibliography accompanying this report might also be consulted for methods which were deemed helpful in introducing SUM in hospitals and for examples of the experiences encountered when good procedures were not followed.

[5]This paper can be found in *Advanced Management,* Vols. 15–16, January 1950, pp 9–11 or in *The Planning of Change* edited by Warren G. Bennis and others, New York: Holt, Rinehart and Winston, 1962, pp. 543–548.

[6]In *Human Relations,* Vol. 14, Number 4, 1951, pp 381–392 or in *The Planning of Change* cited above, pp 698–706.

[7]In W. F. Whyte, et al., *Money and Motivation,* New York: Harper and Brothers, 1955, pp 90–96 or in *The Planning of Change,* cited above, pp 587–591.

[8]In *Harvard Business Review,* Vol. 45, 1967, pp 119–128.

BIBLIOGRAPHY

Complied and annotated
by
Andrea Sperlbaum, M.L.S.

Asselmeier, Doris. "Pediatric Unit for Children" *Nursing Forum,* Volume 3, Fall 1964, pp. 81–95

JOB DESCRIPTION—The unit manager: is responsible for the proper functioning of the physical plant; discovers environmental and mechanical problems and refers them to the proper department for correction; coordinates the activities of the dietary department and the laboratory as they pertain to the unit; supervises a courier and a secretary who transport patients, secure equipment, work on patient charts, order supplies, and take care of admission, transfer and discharge.
OBJECTIVE—To relieve the nurse of non-nursing duties and free her to concentrate on nursing.
EXPERIENCE—No actual experience was discussed.

Barrett, Jean. "The Head Nurse's Changing Role" *Nursing Outlook,* Volume 11, November 1963, pp. 800–804

JOB DESCRIPTION—In this review of the head nurse's role the duties of the unit manager are described as: to "—coordinate ward activities with those of other departments, organize and administer all activities not directly related to patient care, direct and supervise clerks, and carry out receptionist activities."
OBJECTIVES—To free the head nurse from managerial and coordinating activities.
EXPERIENCE—No actual experience was discussed.

"Bellevue Tries Out Unit Manager" *American Journal of Nursing,* Volume 66, February 1966, p. 239

JOB DESCRIPTION—The unit manager is a liaison with other departments having responsibility for equipment and supplies, arranging clerical assistance for the medical-nursing staff, and scheduling patient appointments.
OBJECTIVES—To "—test value of the unit manager system in easing the nursing shortage and maintaining proper care of patients."
EXPERIENCE—The results of this experiment were not given.

Birney, Martha. How the Unit Manager Can Work with Central Service" *Hospital Topics,* Volume 46, June 1968, p. 137

EXPERIENCE—A discussion of the unit manager's relationship with central service at the University of Kansas Medical Center. The unit manager maintains an inventory control of central service.

Blickensderfer, Bertha. "Unit Manager can Help in OR, Too" *Modern Hospital,* Volume 108, January 1967, pp. 97-98

JOB DESCRIPTION—The unit manager schedules operations, forwards charges to the business office, establishes inventory levels, maintains all operating room records, and completes administrative reports. The manager conducts departmental meetings, keeps the personnel records of operating room personnel, does stocking and maintenance of all supplies, maintenance of all surgical equipment and tests surgical cleanliness of the department. He reports to the operating room supervisor and is responsible for four operating rooms.
OBJECTIVES—To relieve the operating room supervisor of routine administrative duties and allow her to devote time to supervision and training.
EXPERIENCE—Unit management resulted in savings due to inventory control and improvement in the booking of cases. The project at Christian Hospital, St. Louis, was felt to be completely justified.

Booth, Marie. "The Area Supervisor" *Hospital Management,* Volume 101, June 1966, pp. 61+

JOB DESCRIPTION—The supervisor, who is a nurse, schedules patient examinations and treatments, financial arrangements, services to the patient, room cleaning, and repairs.
OBJECTIVES—To develop total patient care in a 443 bed tuberculosis hospital of many small units spread over 43 acres, Tucson Medical Center, Tucson, Arizona.
EXPERIENCE—Shows the success of the project depends on the selection of a supervisor. The supervisors have to be able to accept and exercise the authority they receive, and the authority must be clearly defined. Area supervision was first used in medical and surgical areas, then expanded to pediatrics and obstetrics. Plans include expansion to other areas: the emergency room, intensive care units, and the recovery room.

Bosworth, Patricia. "Project Report of Unit Management" *Texas Hospitals*, Volume 22, August 1966, pp. 20+

JOB DESCRIPTION—The unit manager training program of 13 weeks at the University of Texas Medical Branch Hospital, Galveston, covers "—management principles, human relations training, principles of counseling, and the unit clerk training program." Candidates are selected on the basis of results of psychological tests (California Personality Inventory). The unit manager is responsible to the hospital area administrator. There is one unit manager for each shift, with clerical help from 7 a.m.–8 p.m. and 3p.m.–11 p.m.
OBJECTIVES—Decreased administrative duties for nurses and better utilization of nurses for patient care.
FINDINGS—Non-nursing functions were established and it was shown how they could be delegated. A procedure manual was written identifying non-nursing duties of the clerk; a compendium of laboratory tests was compiled (including the purpose of the test, how to collect the specimen, which requisition form to use, and where to send the specimen).

Brady, Norman A., Herman, James A. and Warden, Gail R. "The Unit Manager" *Hospital Management*, June 1966, pp. 30–36

JOB DESCRIPTION—Unit managers at Presbyterian-St. Luke's, Chicago, are college graduates, predominately male, who report to the hospital administration. They have a three week training period in the hospital. Their major function is transcription and processing of physicians' orders. The unit manager is responsible for three adjacent units, or 90 beds, with one assistant unit manager and one or two clerks.
OBJECTIVES—To have a "direct extension of management to the patient care unit and a professionalization or reprofessionalization of the registered nurse to allow her to function most effectively."
EXPERIENCE—The unit manager program was expensive, but worthwhile. Quality of patient care, organization of related services, and nursing morale and recruitment improved. Nursing organization was restructured, dividing nursing into specialties with a director of each specialty. Each patient care unit had a coordinator of nursing responsible to the section director.

Brodt, Dagmar E. "The Service Manger: Innovation for Nursing and Health Organizations" *Hospital Progress,* Volume 47, September 1966, pp. 69+

JOB DESCRIPTION—The responsibilities are mainly supervisory and managerial. The unit manager supervises ward clerks who transcribe physicians' orders and do general office work and service aides who replace supplies, do emergency cleaning, clean service and utility rooms, and take care of non-routine dietary functions.
OBJECTIVES—To better utilize the nurse and extend administration to the level of patient care.
EXPERIENCE—The article shows the unit management system requires planning and integration into the social system of the hospital and the patient unit.

Conner, Hatcil L. "The Departmental Administrative Assistant—A New Career in the Hospital" *Hospital Management,* Volume 103, May 1967, pp. 33–37

JOB DESCRIPTION—The administrative assistant at The Ohio State University Hospitals may be male or female, with no set age limit, have a bachelor's degree in business with three to five years experience in a business situation or two years of college or business school education, with two years experience. The duties include planning, developing, and directing a centralized system of all administrative functions of the department; coordinating administrative activities for the department; and serving in a staff capacity in assisting, advising, and informing the department head and the hospital administrator in formulating the department's administrative policies and applying procedures. His work with personnel involves budgeting, interviewing, maintaining files for employees, discussing grievances, keeping records, and making known changes in personnel policy. He is responsible for preparing purchase and work order requisitions and receiving equipment and supplies. He also keeps patient statistics and maintains financial data on department collections, arranges travel, and assists as a liaison with the housekeeping and nursing service, plus general administrative duties. He is responsible to the department head.
OBJECTIVES—To relieve the department head of administrative functions.
EXPERIENCE—The program at this hospital started in 1957 with an assistant in X-ray and has expanded to seven assistants.

Dennison, Ann J. "Pavilion Manager" *Modern Hospital,* Volume 80, June 1953, pp. 79–80

JOB DESCRIPTION—The unit manager at New York Hospital is responsible for: ordering supplies and maintaining equipment; patient transportation; relieving the floor clerk on the telephone; assigning beds to newly admitted patients; checking on the budget; and answering questions. A high school education is considered a minimum; and experience in a business office is advantageous. There is a period of inservice training.
OBJECTIVES—The unit management system saved time for the head nurse. The support of the head nurse is required for acceptance of the system by the rest of the staff.

Dibble, Elmer E. "Activities of Unit Manager at Mercy Hospital" *The Unit Management Concept in Hospital Patient Care,* Catholic Hospital Association, 1969

JOB DESCRIPTION—The primary function of the unit manager is to supervise and coordinate all non-nursing activities on the nursing unit. The article treats the unit manager's relationship with each department in the hospital, detailing his responsibilities in dealing with each of these areas, i.e., the whole paper is a complete job description for a unit manager in this hospital. It concludes with a description of the daily routine followed.

Donnelly, Cynthia. "Why Not Try Floor Managers?" *Hospital Progress,* Volume 33, February 1952, p. 55

JOB DESCRIPTION—Floor managers are described as "—combination housekeepers and liaison officers with the public and hospital patients." They should have the ability to get along with people.
OBJECTIVES—To remove non-nursing duties from RNs.
EXPERIENCE—The program started as a volunteer program with half-day help, but was switched to a full-time position on the hospital staff.

Dudley, Martha. "Here They Let Nurses Be Nurses" *RN,* Volume 24, September 1961, pp. 53+

JOB DESCRIPTION—The unit manager of Middlesex General Hospital, Brunswick, New Jersey, assists with admissions and discharges, visits patients daily, enforces hospital rules, supervises housekeeping personnel on the floor, is responsible with the head nurse for proper functioning of all equipment, estimates

supply needs each week, and handles incident reports and insurance forms. The public relations aspect of this position was considered important. Young men with college degrees, who were paid on the same level as head nurses, were employed.
OBJECTIVES—"To free nurses to give more and better nursing care."
EXPERIENCE—The objective was achieved; opinions were expressed that nurses would no longer wish to operate without floor managers. Head nurses benefited the most in time saved. The nurses felt that they would rather have men managers than women. The only recurring problem reported was that of staff nurses taking requests directly to the unit manager instead of channeling them through the head nurse.

Dykeman, Alice. "Patient Services Department" *Texas Hospitals,* Vol. 25, June 1969, pp. 28–29

JOB DESCRIPTION—The unit manager is responsible for linens, supplies and equipment, clerical work, errands, patient transportation, administrative assistance to patients, maintaining the physical environment, inspecting and reporting needs for repairs, and coordination of administrative and service functions.
OBJECTIVES—To give the nursing personnel more time to devote to patient care.
EXPERIENCE—It was felt that patients benefited by the service supervisor's inspection of their rooms and that nursing personnel could devote their time to nursing the patients exclusively. Ward clerks were included in "patient services department," which had a total of 70 employees after one year of operation.

Ferriss, Margaret J. and McWillie, Nancy A. "Unit Management in the Operating Room" *Hospital Topics,* Volume 41, December 1963, pp. 69–71

JOB DESCRIPTION—The unit manager: prepares the budget; approves requests for equipment; recommends items for purchase; sets safety standards; studies methods improvement in the operating room; maintains and plans operating room facilities to meet requirements of the surgical services; approves all requests for personnel; is responsible for orientation, inservice training, supervision and evaluation of aides, orderlies and clerks, and schedules their work assignments. The unit manager is the liaison with the nursing service, all the departments of the hospital, and

the surgical advisory committee. He is responsible to the administration.
OBJECTIVES—To separate nursing from managing to obtain "—efficient, safe, and quality patient care."
EXPERIENCE—Better patient care was provided and better service given to the surgical staff. A detailed comparison was given of responsibilities of the unit manager and the nursing supervisor, as practiced at the University of Florida Hospital, Gainesville.

"Floor Help Is Available" *Modern Hospital,* Volume 95, September 1960, p. 76

JOB DESCRIPTION—The unit manager has responsibility for control of supplies and equipment, supervises housekeeping personnel, and the serving of meal trays. The person should be a mature woman seeking permanent employment, active, and with sufficient intelligence to learn administrative routines.
OBJECTIVES—Someone to relieve nurses of some ward duties and supervise maids.
EXPERIENCE—Information came from the experiment in unit management conducted at Sinai Hospital in Baltimore.

Gizzi, James C. "Planning for Developmental Stages of Unit Management" *The Unit Management Concept in Hospital Patient Care,* St. Louis: Catholic Hospital Association, 1969

JOB DESCRIPTION—Responsible for clinical secretaries and housekeeping personnel on the units. Has direct responsibility for supervision of supportive services personnel.
OBJECTIVES—Free nurses to devote more time to nursing care.

Gladstein, Solomon, Prasatek, Genevieve and Thorne, Morris A. *A Floor Manager Pattern for the Nursing Unit.* Sinai Hospital, Baltimore, Md., 1959, 51 pp.

JOB DESCRIPTION—The primary function of the unit manager is to serve the needs of the head nurse. Managers are responsible for preparing and processing patients' menus, distributing nourishment between meals, training new employees, escorting patients, maintaining equipment and furniture, and, on occasion, answering patient lights. The maids are responsible for housekeeping functions, dietary tray service, and preparing rooms for new patients and report to the unit manager. On the postpartum maternity unit, the unit manager acts as a communications link

between the admitting officer and the head nurse. The requirements for the position were: mature woman, aged 25–40, seeking permanent employment, sufficient intelligence to learn hospital administrative routines, ability to supervise, and a high school education.

OBJECTIVES—Improving patient care by relieving nurses and dietitians of non-nursing and nonprofessional duties, "—to reduce specialization in the performance of menial and semiskilled procedures of the nursing unit," "—to obtain maximum supervision at the point of direct service to patients," and to increase the effectiveness of the head nurse by simplifying the administration of the nursing unit.

EXPERIENCE—The study period was one year. Two units, a 31 bed medical-surgical unit and a 28 bed postpartum maternity unit were selected for the experiment at Sinai Hospital, Baltimore. Six unit managers were employed. They were responsible to the project director (an assistant hospital director). The training program lasted for two months and included orientation, lectures and on the job training.

It was felt that both the general and specific objectives were achieved. Operating costs increased equivalent to the managers' salaries. The functions of the dietary and housekeeping departments were altered. Housekeeping was relieved of all responsibility on the inpatient units. A new department of floor management was created.

Hamilton, Lowell Allen. *Nursing Costs and the Unit Manager; A Comparative Study* (Unpublished Master's Thesis. Xavier University, Cincinnati, Ohio, 1965) 72 pp. Xerox copies available from University Microfilms, Inc., Ann Arbor, as *Abstracts of Hospital Management Studies* Document No. NU1143

JOB DESCRIPTION—Three hospitals with differing forms of management were studied. In the hospital where the unit manager is responsible to the hospital administration, the manager and clerks maintain the supply stock, do paper work and generally provide auxiliary services for the nurses. In the hospital where the "division steward" reports to the nurse in charge of the patient floor, the manager (steward) represents the nurse to other departments and to the nursing staff in matters relating to personnel policy, supervises the clerks and aides, keeps records, maintains standards of equipment and supplies, keeps an inventory, talks to salesmen, and performs minor repairs on equipment.

OBJECTIVES—To alleviate the nursing shortage and relieve the nurses of many administrative tasks.
FINDINGS—In the University of Florida Hospital where the manager reported to the administration, a 65 bed medical floor and a 64 bed surgical floor were studied by work sampling. As a result of the program, the nurse spent more time with the patient and the nursing shortage was slightly eased.

In the University of Kentucky Hospital where the manager reported to the nurse, it was felt that the unit could be operated more successfully with the nurse in charge because: (1) problems can be handled by the director of the nursing service without involving another department; (2) closer coordination between the duties of the steward and the nurse in charge is possible; (3) the nurse in charge has total control of the floor.

As compared to the traditional nursing organization used at the University of North Carolina Hospital, fewer levels of supervisory personnel are used in the unit management system. The cost of nursing and administrative personnel for the patient units is lower in hospitals using the unit management or steward program.

Hannan, C. Phillip. "Planning and Implementing a Workable Unit Management System" *Hospital Progress*, May 1969, p. 120

JOB DESCRIPTION—The unit manager is responsible for clerical services, including transcribing doctors' orders and requisitioning supplies. He coordinates activities outside the unit; oversees maintainance of the unit; orients new personnel to unit management (both clerical and nurses); and implements all aspects of a proposed data processing system.
OBJECTIVES—To solve "—the problem of patient care versus paper care."
EXPERIENCE—Director of nursing planned and implemented unit management system, but it is strongly recommended that the unit manager be a part of administration. Nurses, especially head nurses, should be included at all stages of planning. "Most difficult task is to persuade the nurses to give up tradition-bound, non-nursing functions." Nurses need reorientation to nursing and doctors and auxiliary services must be oriented to unit management. Transcription of doctors' orders by unit management was the most difficult for doctors and nurses to accept. Unit management was introduced on one 72 bed medical-surgical unit, with plans to implement systems on every floor until 10 of 15 units are involved from 7 a.m. to 11:30 p.m., seven days a week. Nursing personnel were

exchanged between non-unit management to unit management, also thought to be a worthwhile plan. Costs were slightly reduced due to lower manager salaries and to clerks taking over nurse's clerical work.

Harder, Helen I. "Steward Program Provides Administrative Assistants for Nurse Supervisors" *Hospital Topics,* Volume 41, November 1963, pp. 75–78

JOB DESCRIPTION—The University of Kentucky "division steward" is responsible to the department steward (an administrative assistant to the director of nursing services) for some functions: payroll; gathering data for budget preparation; and questions regarding personnel policies. In the division of surgery, the division steward is an administrative assistant to the assistant director of nursing services. He represents the assistant director to other nursing services and to other departments such as housekeeping and maintenance. He coordinates routine and special cleaning activities of the housekeeping staff, works with dietary in ordering and receiving nourishments for the operating room, maintains a stock of poison control items in the emergency room, maintains equipment and supplies in the operating room and office, represents the assistant director to the nursing staff in personnel policy matters, supervises clerk-typists and unit aides, and keeps records pertaining to the division budget. Qualifications for division steward are: man or woman with a high school diploma and at least five years relevant experience which should include two years in a supervisory capacity or a baccalaureate degree and two years related experience including six months of supervisory experience.
OBJECTIVES—To alleviate the nursing shortage.
EXPERIENCE—Nurses were freed to carry out professional duties. The assistant director of nursing was relieved of administrative duties and was able to spend more time in giving optimal patient care.

Hartman, J. "Floor Managers Share Responsibility in This Food Distribution System" *Modern Hospital,* Volume 100, February 1963, p. 124

JOB DESCRIPTION—Duties of the unit manager include: coordination of departmental services; some clerical work and serving non-medical needs of patients; responsibility for assembly of food and utensils and deliveries of trays to patients; maintaining floor

stocks of nourishment, and "force fluids" supplies; supervision of refreshments; and responsibility for unit housekeeping, disinfection, maintenance of equipment and supplies, and making unoccupied beds.
OBJECTIVES—The improvement of patient care.
EXPERIENCE—One floor manager could supervise a 40 bed unit during the day or two adjacent units (80 beds) on the evening shift. It was concluded that the system may add to operating costs but improvement in patient service and time saved justifies the increase. Some areas of conflict with nursing traditions were found.

Hassan, William E. "Describes Problems, Limited Success of Unit-Manager Program" *Hospital Topics,* Vol. 47, June 1969, p. 28

JOB DESCRIPTION—College graduates with an interest in the type of work. They coordinate inter-department functions and control and procure supplies.
OBJECTIVES—Relieve nurses of administrative function so they can deal with clinical problems.
EXPERIENCE—Program was judged to be a limited success. Problems were: nurses' reluctance to relinquish non-clinical duties; high personnel turnover; manager assigned too large an area to supervise adequately; removal of unit management from control of nursing director; and the requirement that managers be college graduates. No training other than on the job. Program will be changed to put unit management under control of the nursing service and high school graduation will be a requirement. Managers will be responsible to nursing supervisor of their pavilion. Formal training programs to be set up. Managers will be assigned to smaller areas. "Activities of the unit manager will be limited to supplies, physical plant equipment, supervision of unit aides, supervision of unit secretary, and control of patient movement from pavilion to other hospital areas."

Hauck, Leon C. "The Area Administrator—A Remedy for Misplaced Responsibility" *Hospital Forum,* Volume 8, March 1966, pp. 40+

JOB DESCRIPTION—The duties are outlined broadly in five areas of responsibility: systems, services, supplies, personnel, and equipment. The area administrator for the pilot program was on an acute 70 bed medical-surgical unit, supervised ward clerks and reported directly to the hospital administrator.

OBJECTIVES—To allow the nurse to perform direct patient care and to relieve the nursing shortage.
EXPERIENCE—The hospital, Los Angeles County Olive View Hospital, is a long-term care facility treating tuberculosis and chest diseases with about 25% of the beds used for medical-surgical cases. The research on unit management systems was carried out over a year. Nurses were returned to direct patient care, and the nursing shortage was relieved but there was a problem of personnel resistance to change. It was recommended that personnel be educated before the unit management system is started to lessen this problem.

Hawkins, James L. *The Ward Manager System: A Case Study of the Organization of Hospital Nursing* Care (Unpublished Ph.D. Dissertation. Purdue University, 1964) 323 pp. Xerox copies available from University Microfilms, Inc. Ann Arbor, Michigan, as *Abstracts of Hospital Management Studies* Abstract No. NU1145

JOB DESCRIPTION—The unit manager screened phone calls to the head nurse, checked charts for nursing notes, took the ward census, controlled and replaced suture sets and razors, and got schedules from X-ray. With the ward clerk, the manager helped put stock drugs away, obtained equipment, and took charge of patients' possessions. The ward clerk ordered stock drugs, and IV's and special drugs, checked the supply of sterile packs, and checked the charts for stationery.

It was recommended that a female unit manager have at least two years of college education, especially in business administration or equivalent experience. The supervisor of managers could be a graduate hospital administrator or could be recruited from the ranks of the managers themselves. The unit manager should remain as part of the nursing service. (The administration had shown itself unwilling to become involved in such activities.) The system should be run as an autonomous part of the nursing service.
OBJECTIVES—To relieve the nurse of her non-nursing administrative tasks, thereby relieving the nursing shortage.
FINDINGS—The study was in a male medical ward with a census of 28 in a university medical center. The unit manager was a hospital administration resident, who reported to the associate director of nursing services. He was a peer of the head nurse. The ward was studied before unit management and three months after the unit management program had been in operation. Work sampling

and interaction studies were performed before and after the change. It was found that nurses willingly transferred administrative work to the unit manager, but the amount of bedside care did not increase. The nurses wanted to remain free to manage and direct bedside care given by others, due to the low ratio of nurses to semi- and non-professional personnel.

Henderson, Cynthia. "Freeing the Nurse to Nurse" *American Journal of Nursing,* Volume 64, March 1964, pp. 72–77

JOB DESCRIPTION—In this survey of hospitals having unit management, the composite unit managers' duties are given as: "—coordinates and provides services, supplies, and equipment to the patient care unit; assumes responsibility for establishing and maintaining a satisfactory physical environment in the patient unit . . . ; orients, trains, and supervises unit clerical and messenger personnel; coordinates clinical appointments, medical tests, therapy, visiting, nourishment; serves as a liaison between the patient unit and other departments (for example, he helps establish standards or levels of supplies); prepares or assists in the preparation of the unit budget." The unit manager should be mature, have two to four years of college education and several years of work experience including decision-making and supervisory work. In some of the hospitals surveyed, the manager reported to the administration, in others to the unit manager coordinator or to the nursing service.
OBJECTIVES—To free nurses from non-nursing functions.

Houtz, Duane T. "The Unit Manager in the Hospital Organization" *Hospital Progress,* Volume 47, February 1966, pp. 73–78

JOB DESCRIPTION—The unit manager: is responsible for maintaining all supplies, equipment and furnishings on the unit; handles all budgetary matters and approves expenditures; supervises all clerical activity, and coordinates supportive services; spends a great deal of time supervising, training and working with ward clerks, who transcribe doctors' orders, handles all communication regarding the patient and acts as receptionist. Difference between care units determine duties of the unit manager.
OBJECTIVES—To give the best patient care at the lowest cost, and to improve management support to nursing.
EXPERIENCE—There was a problem with training and selecting the managers because of the high rate of turnover. Cost increased due to the division of the nursing unit staff.

Houtz, Duane T. "Unit Manager Plan Provides Administrative Control of Wards" *Modern Hospital,* Volume 99, August 1962, pp. 75–76

JOB DESCRIPTION—The unit manager: works with the clerical staff in transcribing doctors' orders, patient transportation, and other ward clerk activities; supervises and maintains equipment and supplies; hires and trains ward clerical personnel; assists with budget preparation; and represents the administration to patients on the unit. The unit manager must undergo a training program consisting of a period of clerkship, extensive interviews with hospital department heads, and an apprenticeship with other unit managers.
OBJECTIVES—To free the nurse from non-nursing duties.
EXPERIENCE—The nurse was freed from many non-nursing functions, but no evidence of increased time spent with patients was available. Costs were the same as a system without unit management.

Howe, Arlene. "Supervisors Coordinate Patient Services" *Modern Hospital,* Volume 101, July 1963, pp. 77–81

JOB DESCRIPTION—The unit manager is in charge of clerks, maids, and porters for two 50 bed wards. The unit manager: coordinates "—all floor services contributed by central services, building services (housekeeping), and maintenance;" maintains equipment and supplies and establishes inventory standards; assists in the orientation of nursing students, interns, medical students, and new staff members; and institutes and carries out administrative practices and policies. Clerks transcribe doctors' orders, make patient appointments, and transfer and discharge patients. The dietetic department is in charge of serving the patients' meals.
OBJECTIVES—To eliminate non-nursing activities in the nursing service and to coordinate all activities occurring on the nursing unit.
FINDINGS—Head nurses were quite familiar with the objectives of the program, but staff nurses, medical staff, clerks, and students required more orientation. Nurses did have difficulty in turning over management of the unit to others, but under the new system they have more time for working with physicians. Also, nurses had increased productivity and time spent with patients. Costs did increase, but it was felt that the advantages of the program made up for the increased costs.

Isenberg, Marjorie and Harris, Barbara. *The Effect of the Unit Manager System on Head Nurse Activities* (unpublished Master's Thesis, Boston University, 1967)

FINDINGS—The head nurses on two patient units with unit management and two without unit management were observed for eight and a half hours. The nurses with unit management spent more time in the patient area and less in the nursing station.

A. T. Kerney and Co. *University Hospitals of Cleveland Unit Manager Study*

JOB DESCRIPTION—The unit manager supervises ward clerks, supervises and maintains standards for supplies and equipment, and acts as a receptionist and message center. The unit manager may report either to the nursing service or to the hospital administration.

OBJECTIVES—To relieve nursing personnel of non-nursing duties, improve patient care, raise nursing morale, and obtain "maximum supervision of nonprofessionals at the point of direct service to patients."

FINDINGS—Five general hospitals with 400 or more beds were studied. Management, professional, and nonprofessional employees were interviewed in semi-structured interviews. The data collected included comparisons of the size and complexity of each organization, the number of beds assigned to each service unit, the number of nursing personnel, the number of service unit employees, and operating cost information.

Nurses felt that they had more time for patient care under unit management, but there was little indication of change in the amount or quality of care. Patients in one hospital are said to have preferred units with a unit management system. It was not proven that unit management afforded better personnel utilization. In four hospitals, task assignments of nurse aides and LPN's were not changed by the unit manager system.

Unit management improved cooperation and coordination of the service departments. Data on before and after costs were not obtained, but it was felt that costs were not reduced. (Cost reduction was not an objective.) The major problems were the reluctance of nursing personnel to relinquish duties to the unit manager and finding qualified people to fill the unit manager positions. The study concludes that development of the unit management system should be continued. The unit manager should be responsible to the head nurse and encompass all nonpatient care

activities occurring in the unit. Staff size should not increase to accomodate the unit manager, rather there should be a decrease in the nursing staff.

Letourneau, Charles U. "Unit Managers—One Solution to the Nursing Shortage" *Hospital Management,* Volume 104, December 1967, pp. 31-32

JOB DESCRIPTION—The unit manager is part of the administration. He coordinates supporting services of patient care, identifies the personnel needs of his department, acts as director of personnel in his own department, works with the department director in formulating special personnel policies of the department. He is responsible for the maintenance of all equipment and supplies, maintains a liaison with other departments, and supervises one or more clerks. Unit managers should have a college education in business administration with at least five years of experience in business and should have done purchasing, office management, or personnel work.
OBJECTIVES—To alleviate the shortage of professional personnel and to effectively increase the services of nurses.

McBeth, Max A. and Carpenter, Douglas C. "Seven-year Appraisal of a Ward Manager System" *Hospitals,* Volume 40, March 16, 1966, pp. 79-86

JOB DESCRIPTION—The unit manager at Salt Lake County General Hospital: coordinates non-nursing functions; supervises the ward clerk, the maid and the custodian on the unit; sets standards for supplies; and solves all non-nursing environmental problems on the nursing units. Middle-aged women who were in these positions were part of the administrative staff and were paid in the same salary range as a staff nurse. The requirements were a high school education with three years of hospital experience. Supervisory experience was also preferred.
OBJECTIVES—To free nurses for patient care and to provide an environment in which satisfactory care could be given.
EXPERIENCE—The "Pioneer ward manager" went through one unit at a time and listed building and equipment repairs, initiated a terminal housekeeping plan, and established standard stocks of linen, warehouse, and medical supplies. After this had been done in three units, a new ward manager was hired and trained to take over those units until three ward managers and nine wards were

set up for this system. At first the system was not accepted by the nurses, then their roles were redefined and the morale of the staff improved. Supply functions improved and hoarding of supplies on the unit was stopped. Unit management was extended to seven days a week.

McKenna, J. V. *Final Project Report: The Service Manager System: Nurse Efficacy and Cost.* 1968, 201 pp. Xerox copies available from University Microfilms, Inc., Ann Arbor, Michigan as *Abstracts of Hospital Management Studies* Abstract NU 1065

JOB DESCRIPTION—The unit manager works with unit secretaries and reports to the service manager supervisor who trains him. The manager is responsible for housekeeping, dietary and clerical functions.
OBJECTIVES—To "—relieve the nurse of the major service functions she ordinarily performs on a traditionally organized nursing unit . . . The nurse no longer has to perform, or even supervise, these activities."
FINDINGS—A surgical unit and medical unit with unit management were compared to traditionally managed surgical unit and medical unit at Barnes Hospital, St. Louis, in a three year study. The activities of unit personnel, patient care, and cost were compared. Charge nurses and team leaders on both medical and surgical units with unit management spent more time on nursing level activities than nurses on the traditionally managed unit. A new type of nursing supervisor "—with minimal administrative functions and strong patient care responsibilities" was a factor in the development of the lay managed units.

There was no significant difference in patient welfare (equated with rate of recovery) on the two differently managed units. Data on cost were inconclusive; nursing care could not be measured directly; and no significant differences were found in length of stay on the test units.

It was found that service management did focus nursing activities on patient care; service personnel took over functions performed by nurses; and service management is equal to traditional management in providing for patient welfare.

McKenna, J. V. "Service Management in Nursing Homes" [sic] *Hospitals,* Volume 42, September 16, 1968, pp. 78+

JOB DESCRIPTION—The service manager system is described as consisting of service manager, service clerk, and service aide on

each unit. They perform management, clerical, housekeeping, and dietary functions.
OBJECTIVES—To: improve patient care; relieve the nursing shortage; provide supervision on the unit of many housekeeping, maintenance, dietary, and clerical functions.
FINDINGS—Four nursing units were studied at Barnes Hospital, St. Louis. One medical and one surgical were managed in the traditional manner with the head nurse in charge. The other medical and surgical were managed by the service manager, with the head nurse in charge of nursing functions. Job descriptions were written for all personnel on all four units and used as performance objectives. There were no final results included in this description of a study.

Manion, Mary E. "New Aid for Your Hospital Work" *Medical Economics,* Volume 44, February 6, 1967, pp. 98–102

JOB DESCRIPTION—The unit manager is responsible for admissions, transfers and discharges, housekeeping, equipment and supplies, transcription of physicians' orders, medical records, and laboratory tests.
OBJECTIVES—To relieve the nursing shortage at Presbyterian-St. Luke's, Chicago.
EXPERIENCE—The deactivation of one patient unit, which meant a loss of 150 patients per month was a major force in starting this program. The patient unit was reopened and 19 additional beds were put into service. Administration in the individual units was improved; equipment was readily available; and the lines of communication shortened. The nursing shortage was all but eliminated. The tripartite system of resident, nurse, and unit manager gave the manager the advantage of independent action.

Martin, Samuel P. "Medical Staff Agrees; Unit Plan is good for Patients" *Modern Hospital,* Volume 99, August 1962, pp. 76+

JOB DESCRIPTION—The role of the unit manager is viewed as that of the representative of the hospital administration at the patient level.
OBJECTIVES—The objective was better patient care, to be achieved by giving doctors and nurses more time to spend in patient care.

EXPERIENCE—The unit management system saves hours of nursing time but doctors and nurses have not learned to take advantage of this extra time. Without the head nurse, the doctor had no one person to contact for all problems. There was a role conflict between the unit manager and the nurse, but eventually a balance was reached.

Mercadante, Lucille T. "Functions and Benefits of the Unit Manager" *Hospital Progress,* Volume 47, January 1966, pp. 114–117

JOB DESCRIPTION—The unit manager at the University of Florida Hospital has management responsibilities on patient floors, operating rooms, central supply; is responsible for the operation of a particular unit at all times; and acts as the liaison between the administration and the patient care units. He reports to the assistant director of the hospital.
OBJECTIVES—To provide administrative control at the ward level, and to help increase nursing care time by relieving the nurse of the mangement responsibilities of the over-all operation of the patient unit.
EXPERIENCE—There were problems of resistance to change. For example, the medical staff did not like to have the requests made of the nurses referred to the unit manager. Also, there was the question of who had the final authority. Preliminary studies showed in this hospital that nurses were spending more time with patients than in other hospitals.

Mercadante, Lucille T. "An Organizational Plan for Nursing Service" *Nursing Outlook,* Volume 10, May 1962, pp. 305–306

JOB DESCRIPTION—The unit manager at the University of Florida Hospital reports to the assistant director of the hospital and is responsible for the general administrative operations of a floor: supplies, equipment, cost control, housekeeping, records, and many clerical minutiae.
OBJECTIVES—To free the nurse to give better nursing care, to involve the administration more in patient care and to alleviate the nursing shortage.
EXPERIENCE—Clerical duties for nurses were kept at a minimum. Nursing personnel were conserved; the hospital was staffed with approximately fifty percent less supervisory nurses than a comparable hospital and the standards of patient care were raised.

Mercadante, Lucille T. "Unit Manager Plan Gives Nurses Time to Care for the Patients" *Modern Hospital*, Volume 99, August 1962, pp. 73–75

JOB DESCRIPTION—The unit manager is to "provide hospital administration with function control at the patient floor level." He is on a peer relationship with the nurse in charge and the chief resident of the floor.
OBJECTIVES—To "—bring hospital administration into a closer working relationship with medical and nursing practice at the patient floor level and to help the administration coordinate the multidisciplinary approach to total patient care at its source."
EXPERIENCE—With the unit manager system the nurses had time to devote to study patient care needs. Nursing practice was thought to be improved and the administration was brought into the patient care unit.

Miller, John L. "Is There a Nurse Shortage" (Part I of a two-part study) *Nursing Homes*, August 1969, pp. 18–20+
Clark, Kaye R. and Miller, John L. "The Unit Director: A Partial Answer to the Shortage of Nursing Services" *Nursing Homes*, September 1969, pp. 20–21. (Part II)

JOB DESCRIPTION—The unit director is the administrative head of all activity performed on the units being supervised and reports directly to the director of nurses. While the professional nurse is responsible for all professional nursing decisions made, all other aspects of her performance fall within the scope of authority of the unit director.
OBJECTIVES—Better or more professional treatment of patients without adding more high-paid staff.
EXPERIENCE—Time spent by nursing in patient care increased to 53.6% and administrative clerical decreased to 10%. There was also an increase in time spent in non-work activity (14.4% to 17.8%). It was decided that one manager could cover two 41 bed wards. Recommended that the program be introduced to nurses well in advance. For introductory unit, an intelligent progressive nurse who was flexible enough to experiment and a non-medical person familiar with hospital operations were sought. First unit manager was an associate degree nurse from a junior college which specialized in "medical arts."

Moshier, Virginia M. "Nurse Comments on Unit Supervisor Plan" *Modern Hospital,* Volume 108, January 1967, p. 67

EXPERIENCE—Replies to four questions about unit management program at The University of Michigan state that nursing personnel spend more time in patient care although the amount of patient care often does not allow head nurses time for teaching and supervision. At the beginning of the program, doctors regretted the passing of the "old head nurse" who handled all their problems. There were still nursing shortages, but the nurses found nursing easier after unit management. Experience showed that the change takes longer than predicted; non-nurses do many functions better than nurses, and nurses have more time for direct patient care.

Nellis, William. "Unit Managers Cut Patients' Complaints 50 Percent" *Hospital Topics,* Volume 46, June 1968, pp. 42–45

JOB DESCRIPTION—The unit manager at Beth Israel Hospital, Boston, as a representative of the administration, handled visitor and noise control, inspections of patients' rooms, and acquisitions of supplies and equipment.
OBJECTIVE—Better patient care.
EXPERIENCE—It was thought that patient care had improved since there was a fifty percent reduction in patient complaints. Cost of supplies dropped even though census increased. Revenue increased due to tighter control of patient charges.

Nelson, Roger B. "Full-Time Nurses Should Nurse Full Time" *Modern Hospital,* Volume 108, January 1967, pp. 66–67

JOB DESCRIPTION—Duties of a "service organization" included: transcribing doctors' orders; scheduling patient appointments; admissions and discharges; daily census; the provision of supplies and equipment, housekeeping in the unit, patient transportation and all clerical functions.
OBJECTIVES—To alleviate the nursing shortage.
EXPERIENCE—Unit management is viewed as one of several ways to alleviate the nursing shortage.

"New York Hospital Reassigns Duties in Nursing and Housekeeping Departments" *American Journal of Nursing,* Volume 47, December 1947, p. 838

JOB DESCRIPTION—A registered nurse acts as supervisor of women attendants, clerks, and orderlies in the nursing service. She also works with housekeeping to coordinate the division of duties between the two departments so that supplementary workers in the nursing service can devote more time to nursing related duties.
OBJECTIVE—To relieve nurses of non-professional duties and to release more of their time for direct care of the patient.
EXPERIENCE—The program was successful in an experiment on two floors. Inservice training for the supplementary nursing service staff was established under the direction of the nurse administrative assistant. A registered male nurse will supervise the orderlies.

"Non-Nurse Managers for Hospital Divisions" *American Journal of Nursing,* Volume 52, March 1952, pp. 323-324

JOB DESCRIPTION—The unit manager at the Memorial Center for Cancer and Allied Diseases in New York City is responsible for auxiliary services provided to the patient and for maintenance of equipment; he supervises housekeeping, takes charge of mail and gift deliveries to patients. He belongs to the administrative staff and is responsible for a 39 bed ward seven days a week.
OBJECTIVES—To relieve nurses of non-nursing duties so they can spend more time with patients.

It was felt that the experiment in unit management was justified and would expand to the entire hospital. It was liked by the nurses, doctors, administrators, and other full-time personnel because of better patient care and savings in time, energy, and money.

Palmer, Helen. "Nurses for Nursing" *Canadian Nurse,* Volume 65, May 1969, pp. 36-39

JOB DESCRIPTION—The duties of the ward manager were: to cooperate with the head nurse and her staff in providing a clean, tidy, pleasant environment as economically as possible; to handle the budget for the floor and to consider carefully all expenditures; to maintain all ward supplies, equipment, and furnishings and to supervise their use; to coordinate the departments of housekeeping, pharmacy, diet kitchen, laboratory, and X-ray to facilitate good patient care.
OBJECTIVES—To free the head nurse for patient care.

EXPERIENCE—Immediate results were encouraging. Many non-nursing functions were transferred to unit manager and head nurses can concentrate on supervision and planning patient care. Little change was noticed in quality of physical care, but emotional and social needs were better met.

Patterson, Thora K. "Patient-Centered Nursing" *Hospitals,* Volume 41, November 1, 1966, pp. 80+

JOB DESCRIPTION—The service supervisor is responsible for: the unit supplies and their transportation; coordination of patient care activities originating in other departments; the physical environment of the unit, including repairs; and the supervision of the clerks and scheduling of their hours. The clerks transcribe doctors' orders, handle reception and communication.
OBJECTIVES—To allow the nurse more time for nursing.
EXPERIENCE—This program was thought to be too expensive for hospitals with less than 200 beds. It requires careful preparation of nursing and non-nursing personnel. Costs rose, but the increased costs were thought to be offset by increased nursing care. Careful preparation of nursing and non-nursing personnel is required. Managers had a three week orientation program.

Regan, Patrick A. "Measuring the Effectiveness of a Unit Management Program" *Hospital Progress,* Volume 50, December 1969, pp. 28-33

JOB DESCRIPTION—The Patient Service Coordinator (unit manager) is the non-transportation half of the Administrative Services Department. He "assumes total responsibility for the clerical work on the nursing unit" (includes equipment and supplies) and assists the head nurse with some management responsibilities.
OBJECTIVES—To increase the time which nurses can devote to direct patient care.
EXPERIENCE—Five factors were selected to measure the effectiveness of the program: (1) registered nurse manhours per patient day; (2) payroll hours per unit; (3) manhours per patient per day; (4) patient incident reports; and (5) patient opinion questionnaires returned. The ratio of RN manhours increased on those units with administrative services. Additional personnel resulted in a significant increase in payroll expense; new administrative service staffing patterns are currently being evaluated. Patient questionnaires revealed an increase in the number of favorable comments

about the nursing care received, and a corresponding decrease in the number of negative responses concerning nursing, laboratory, X-ray, housekeeping, and dietary.

Sister William Mary Brooks. "A Pattern for Unit Management" *Hospital Progress* Volume 48, May 1967, pp. 124–128

JOB DESCRIPTION—In the nine hospitals surveyed, there were differences in title, salary, duties, and qualifications of unit managers. Non-nursing duties included "housekeeping, laundry and linen; maintenance; supplies and purchasing; administrative reports and documents; personnel scheduling and supervision; coordination of patients' appointments . . . ; teaching and orientation of personnel; policy interpretation; procedure review and revision; charts and reports to medical records." The responsibility varies from coordination of departments involved in the unit to supervising personnel on the unit. Education requirements varied from high school education to a college degree. Some hospitals employed unit managers on the evening shift as well as the daytime. Salaries ranged from that of a ward clerk to that of a nursing supervisor. In some hospitals the manager reports to the nursing department and in some to the administration.
OBJECTIVES—Alleviation of the nursing shortage, maintaining a high level of patient care, and coordination of all interdisciplinary activities occurring at the patient level.
EXPERIENCE—One hospital found it necessary to revitalize nurses in the practice of nursing in order to successfully implement unit management.

Sister Mary Vincent. "Floor Managers Lift the Burden from the Nursing Department" *Modern Hospital,* Volume 78, June 1952, p. 62

JOB DESCRIPTION—The unit manager of Spohn Hospital, Corpus Christi, checks rooms and corridors for cleaning, orders supplies, maintains equipment, greets patients and does non-medical errands for them. He is responsible to the hospital administration.
OBJECTIVES—To relieve the nurse of non-nursing duties.
FINDINGS—Nurses were relieved of fifty percent of non-nursing duties. The first response to the unit manager system was lukewarm, but later the system was much appreciated.

Souza, Lawrence E. "Unit Management and the Use of the Clinical Specialist in Nursing" *AORN Journal*, Volume 6, July 1967, pp. 46–49

JOB DESCRIPTION—"Coordination of service, providing the means, and supplying the tools, become primary functions of the service manager." Duties include implementing hospital policies and procedures, and selecting, training, and supervision of personnel.
OBJECTIVES—To let nurses spend time in nursing activities, thereby easing the shortage of nurses.
EXPERIENCE—It is recommended that nursing not be responsible for the unit manager, since this adds another area which nursing service must oversee. When freed from extra duties, the clinical nursing specialist can be used for coordination of nursing care which will benefit the patients.

Stryker, Ruth P. "Hospital Study Leads to Vocational Program" *Nursing Outlook*, Volume 14, August 1966, pp. 33–34

JOB DESCRIPTION—The manager was trained by the head nurse to transcribe doctor's orders and then communicate this information to the nurses and other departments. The ward secretary ordered supplies and equipment, explained hospital policies to visitors, communicated with other departments, kept legal records, kept personnel time schedules, ran errands, kept the bulletin boards up to date, and worked on the pneumatic tube and the patient intercom.
OBJECTIVE—To free the head nurse from transcribing doctors' orders giving her more time to work in teaching and patient care.
FINDINGS—The study involved work sampling the positions of ward manager, head nurse and ward secretary in two 40 bed patient units, at Mt. Sinai Hospital, Minneapolis. One manager was a lay person, one a nurse. The study was to determine: (1) how the head nurse, unit manager and the secretary spent their time; (2) if the head nurse was freed for other duties by the unit manager; (3) the difference between the lay manager and nurse manager; (4) and educational requirements for the secretary and unit manager by analysis of their duties and re-established job requirements. It was found that the ward secretary performed more management functions than anyone else. The manager was primarily involved in indirect patient care. After the initial training period, the lay unit manager was thought to be as capable as the nurse manager. The head nurse had increased time to spend with patients and addi-

tional time was spent by her exchanging information about her patients.

The Unit Management Concept in Hospital Patient Care, Catholic Hospital Association, St. Louis, 1969, 178 pp.

An anthology of papers adapted from Institutes on Unit Management in Pittsburgh and St. Louis.
JOB DESCRIPTION—Guidelines for functions on nursing units under unit management are given in the appendix.
OBJECTIVES—Generally stated to be to relieve nurses of non-nursing duties.
EXPERIENCE—Accounts given of unit management under various types of control, particularly under administration and nursing.

"Unit Management Well Established; Employees Enthusiastic About System" *Hospital Topics,* Volume 44, July 1966, pp. 67+

JOB DESCRIPTION—The unit manager is responsible for all non-nurse activities. Managers are from 25-55 years of age, high school graduates, and have supervisory experience. Salaries range from slightly less than that of a staff nurse to slightly more than that of head nurses. Managers undergo a long orientation and extensive on-the-job training.
OBJECTIVES—The objective is to separate the nursing and management functions and to "create an environment in which the nurse can achieve her professional aims unhampered by nonprofessional duties . . ."
EXPERIENCE—The program resulted in a complete redefinition of some jobs and changed the responsibilities of some of the support services, and new channels of communication were opened. The idea was well received.

"Unit Manager System Tried at One More Hospital" *American Journal of Nursing,* Volume 64, August 1964, p. 42

JOB DESCRIPTION—The unit manager was "responsible for the coordination of the non-nursing administrative functions of the patient unit." He was to: maintain and order supplies and equipment; explain hospital regulations; make daily safety checks; help in the orientation of new patients; arrange transfers and discharges; and notify housekeeping of check-outs.
OBJECTIVES—To give nurses more time with the patient.
EXPERIENCE—No results of the program at Mary Hitchcock

Memorial Hospital, Hanover, New Hampshire, were given. A former Air Force medical technician was employed as unit manager.

Warden, Gail L. "Unit Manager Program: Implications for Central Service" *Hospital Topics,* Volume 46, June 1968, pp. 133–137

JOB DESCRIPTION—The unit manager with his staff at Presbyterian-St. Luke's, Chicago, is responsible around the clock for transcribing doctors' orders and scheduling patient tests and appointments. They handle food service activities, personal services to the patient, admissions, transfers, discharges, patient transportation. Also, they check on activities of housekeeping personnel, call maintenance when repairs are needed, order supplies, equipment, linens and drugs, establish and maintain an inventory, act as a liaison between the unit and other departments of the hospital, supervise clerical procedures, train new personnel, formulate budget, and handle special projects. The manager reports to the hospital administration. The unit manager goes through a four week training program of lectures and laboratory.
OBJECTIVES—The alleviation of the nursing shortage, better utilization of nurses, and an extension of management to the bedside.
EXPERIENCE—The advantages of this program are listed as: improved management of the patient care unit; increased administrative services to patients; introduction of data-processing system for patient charges; improved patient care; and easier nurse recruitment.

The disadvantages are: the increased expense; problems which arise in areas between unit management and nursing; and problems of personalities which are difficult to distinguish from the problems of the program. This system is not applicable to every hospital and it may or may not reduce the nursing shortage.

Ware, Anna V. "What is a Unit Manager?" *AORN Journal,* Volume 4, May–June 1966, pp. 89–92

JOB DESCRIPTION—The unit manager at the University of Illinois Hospital, Chicago, performs the non-nursing functions of the supervisor. She controls "new supplies and equipment, linen and linen inventory, pharmacy supplies, maintenance and physical inventory of all equipment." She is the liaison with the housekeeping and maintenance departments and is supervisor of the clerical personnel. Three clerks and an equipment attendant work for this manager and she schedules their working time and vacations.

OBJECTIVES—To relieve the nurse of non-nursing duties.

Wesbury, Stuart A. and Schwartz, Michael R. "Three-Step Program Lets Night Nurses Get Back to Nursing" *Modern Hospital,* Volume 10, January 1968, pp. 85–87

JOB DESCRIPTION—The duties of the position at the University of Florida Hospital include "1) acquisition and maintenance of supplies and equipment; 2) interservice communication and coordination; 3) interpretation of policies and procedures and the ensuring of timely and accurate compliance; 4) accomplishment of clerical and record keeping detail." The manager is responsible for inpatient units of 60 beds, and has clerical help. He usually works regular office hours, but occasionally will work evenings or weekends. He is responsible for the unit 24 hours a day, seven days a week. Clerks are on duty both day and evening shifts.
OBJECTIVES—The objective was to make evening and night shifts function as much as possible like the day shift with unit management, decentralized nursing service, and available supportive services.
EXPERIENCE—Cooperation between the unit managers and their staff helps relieve the problems which arise on evening and night shifts. Nurses have to be helped to make the transition to unit management. Compatibility between the nurse supervisor and the unit manager is a necessity. There has been criticism of the reporting of the unit manager to the administration. This set-up makes it necessary to see more than one person with a request. Some positions are unnecessary with unit management; the head nurse position is the most frequently affected.

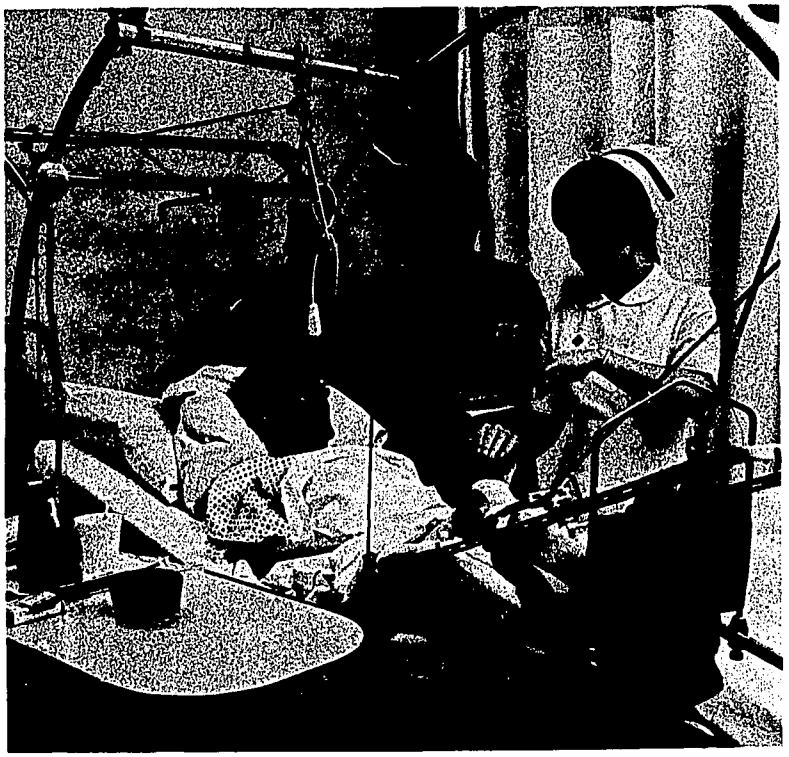
Zimmerman, James P. "Initiating a Unit Management System" *Hospital Progress,* Volume 49, February 1968, pp. 64+

JOB DESCRIPTION—The unit manager at Mercy Hospital, Pittsburgh, is responsible for non-nursing duties on units of 105–155 beds. The pilot area manager had a clinical secretary and received orientation to the nursing service. The starting salary was at the same level as that of the head nurse.
OBJECTIVES—A solution to the problem of the nursing shortage and the growing amount of administrative clerical tasks on nursing units.
EXPERIENCE—An analysis was made of activities of various levels of nursing personnel which showed that nurses were devoting a great

deal of time to non-nursing activities. A list of 69 non-nursing tasks was used as a basis for the unit manager's duties. There were sufficient management duties to require one manager for every three nursing units. The initiation of management was linked to changes in the nursing service: the team nursing concept and change in the concept of the nursing supervisor. Nursing and non-nursing activities were performed satisfactorily with no net increase in personnel costs.

Unit managers were all men, although women were not excluded. None were college graduates, but most had training beyond high school and ranged in age from 39–54.

The objectives were attained. Acceptance of the program by nursing personnel was good to excellent. Duties were extended to include development of supply control procedure. Supervision of housekeeping is done by the manager. The unit manager reports to the assistant administrator.



Unit manager and head nurse conducting rounds